

HEALTH MANPOWER LEGISLATION



HEARINGS
BEFORE THE
SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT
OF THE
COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES
NINETY-SEVENTH CONGRESS

FIRST SESSION

ON

H.R. 2004

A BILL TO AMEND THE PUBLIC HEALTH SERVICE ACT TO REVISE AND EXTEND THE PROGRAMS FOR THE NATIONAL HEALTH SERVICE CORPS AND TO REVISE AND EXTEND THE PROGRAMS OF ASSISTANCE UNDER TITLES VII AND VIII OF SUCH ACT FOR THE EDUCATION OF HEALTH PROFESSIONS PERSONNEL, AND OTHER PURPOSES

AND

H.R. 2056

A BILL TO AMEND THE IMMIGRATION AND NATIONALITY ACT WITH RESPECT TO ALIEN GRADUATES OF FOREIGN MEDICAL SCHOOLS

MARCH 4 AND 12, 1981

Serial No. 97-5



Printed for the use of the Committee on Energy and Commerce

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CONTENTS

Hearings held on:	Page
March 4, 1981.....	1
March 12, 1981.....	255
Text of:	
H.R. 2004.....	3
H.R. 2056.....	94
Statement of:	
Abt, Donald A., D.V.M., on behalf of Association of American Veterinary Medical Colleges.....	370
Aiken, Linda, Ph. D., assistant vice president, Robert Wood Foundation	109
Baerg, Richard, president, American Association of Colleges of Podiatric Medicine.....	370, 378
Bilby, Jack, on behalf of American Association of Colleges of Pharmacy..	370, 402
Blehart, Bruce, legislative department, American Medical Association.....	355
Blendon, Robert J., Sc. D., senior vice president, Robert Wood Johnson Foundation.....	109
Bowie, Walter C., D.V.M., Ph. D., Association of Minority Health Professions Schools.....	256
Cohen, Benjamin, D.O., president-elect, American Association of Colleges of Osteopathic Medicine.....	205, 229
Cooper, Dr. John, president, Association of American Medical Colleges.....	205
Copeland, Mary, National Student Nurses Association.....	167
Donley, Sister Rosemary, American Association of Colleges of Nursing.....	167
Elliott, Paul R., Ph. D., associate vice president for academic affairs, Florida State University.....	256
Gehring, Gerald R., M.D., chairman, board of directors, American Academy of Family Physicians.....	138
Gemmell, Michael K., executive director, Association of Schools of Public Health.....	297
Grace, Helen, National League for Nursing.....	167
Hines, Ralph H., Ph. D., Association of Minority Health Professions Schools.....	256
Holleran, Connie, R.N., deputy director of Government relations, American Nurses' Association.....	167
Jones, Clark, associate director, California Area Health Education Center..	405
Landay, Merwyn A., D.D.S., project director, New Jersey Area Health Education Center.....	405
Payne, John, deputy director, North Carolina Area Health Education Center.....	405
Rabin, David, M.D., past president, Association of Teachers of Preventive Medicine.....	297, 329
Rachal, Anthony, M. Ed., Association of Minority Health Professions Schools.....	256
Reese, Errol, D.D.S., on behalf of American Association of Dental Schools.....	205, 215
Ruhe, C. H. William, M.D., senior vice president, American Medical Association.....	355
Schlegel, John F., Pharm. D., M.S. Ed., assistant executive director, American Association of Colleges of Pharmacy.....	370, 381
Stemmler, Edward J., M.D., on behalf of Association of American Medical Colleges.....	205
Sullivan, Louis W., M.D., president, Association of Minority Health Professions Schools.....	256, 264

Statement of—Continued

Sundre, Steven M., Ph. D., vice president, Association of University Programs in Health Administration.....	Page 297, 319
Tarlov, Alvin, M.D., department of medicine, University of Chicago	138, 154
Tom, Sally Austen, Government liaison, American College of Nurse-Midwives	167, 182
Walker, Charles A., Ph. D., Association of Minority Health Professions Schools.....	256
Young, Robert, M.D., American Academy of Family Physicians.....	138
Additional material submitted for the record by:	
American Academy of Family Physicians, attachments to Dr. Gehringer's prepared statement:	
Attachment A—Results of annual survey of family practice residency programs.....	147
Attachment B—Report of survey of 1980 graduating family practice residents	151
American Association of Colleges of Pharmacy, attachments to Dr. Schlegel's prepared statement:	
Pharmacy/Federal partnership: Directions for the eighties.....	392
Priorities of pharmaceutical education in response to national health needs.....	386
American Association of Colleges of Podiatric Medicine, attachment to Dr. Baerg's prepared statement, resolution on podiatric medical education (adopted by the National Advisory Council on Health Professions Education, Jan. 29, 1980).....	380
Health and the Environment Subcommittee, Energy and Commerce Committee, Congressman Leland's questions and Mr. Sullivan's responses	289
Statements submitted for the record by:	
Ambulatory Pediatric Association	433
American Academy of Pediatrics	429
American Association of Colleges of Nursing.....	512
American Association of Colleges of Osteopathic Medicine.....	572
American College of Cardiology	435
American Hospital Association	449
Association of American Medical Colleges.....	474
Association of Chiropractic College Presidents, International Chiropractors Association, American Chiropractic Association.....	559
Association of Schools and Colleges of Optometry and American Optometric Association	548
Coalition for Allied Health Professions Education.....	529
Federation of Nurses and Health Professions, American Federation of Teachers, AFL-CIO	515
National Student Nurses' Association, Inc	519
Tuskegee Institute School of Veterinary Medicine.....	580
Letters submitted for the record by:	
American College of Surgeons, C. Rollins Hanlon, M.D., FACS	666
American Dental Association, Wilfred A. Springer, D.D.S., chairman, Council on Legislation	659
American Dental Hygienists' Association, Kathy Turbyne, president	601
American Osteopathic Association, John Perrin, director.....	667
American Osteopathic Hospital Association, Michael F. Doody, president..	663
American Psychiatric Association, Melvin Sabshin, M.D., medical director.....	606
California Department of Health Services, Beverlee A. Myers, director	652
Georgetown University, T. Byron Collins, S.J., special assistant to the president for Federal relations	656

HEALTH MANPOWER LEGISLATION

WEDNESDAY, MARCH 4, 1981

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 1:30 p.m., in room 2218, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The subcommittee will come to order.

This afternoon the subcommittee begins its hearings on the extension of the authorizations for the health professions education and nurse training programs. These programs are important because they help assure that the Nation will be properly supplied with highly skilled health professionals over a period running well into the next century.

These hearings and the subsequent deliberations of the subcommittee are more significant this year than ever. Because of the current efforts to reduce the Federal budget, we must be certain that programs are well designed and carefully managed. This is not the time for inefficiency or waste.

But beyond vigilance against waste, I believe we must be careful to insure that the current concern with the budget does not lead us to renege upon our commitment to improve the health care available to the American people. The health care which can be provided by U.S. physicians is the finest in the world. Yet this care is out of reach for many of our people.

The programs authorized by this bill represent our effort to insure that all of our citizens, including those in rural and inner city areas, have reasonable access to first class medical care. These programs are essential to the training of additional primary care physicians and other professionals necessary for a more efficient health care system.

Without these programs, thousands of people including some from minority and other disadvantaged communities, will be forced to abandon their cherished dreams of becoming physicians, dentists, and nurses.

Today's hearing continues a process begun last year, when the subcommittee devoted 6 days to hearings and another 3 days to markup of the health professional legislation. Those efforts produced a consensus that the subcommittee bill, now reintroduced as H.R. 2004, provides a sound balanced health professions policy for the Nation.

This bill was endorsed in the House in September by a vote of 358 to 8. Unfortunately, although the Senate also passed health

professions legislation last year, it was not possible for the conference committee to reach agreement in the last days of the 96th Congress.

In reintroducing last year's subcommittee bill, I want to note that, while I believe this is a good bill, I do not expect the subcommittee to adopt it without revision. The new members of the subcommittee all bring their own views on these issues to our deliberations. Many individuals and associations will also have suggestions for further improvements in the bill.

The introduction of H.R. 2004 in today's hearing is thus only the beginning of a process that I hope will produce strong health professions legislation later this year.

Without objection, the text of H.R. 2004 and H.R. 2056 and any agency reports thereon will be placed in the record at this point.

[Testimony resumes on p. 102.]

[The documents referred to follow:]

97TH CONGRESS
1ST SESSION

H. R. 2004

To amend the Public Health Service Act to revise and extend the programs for the National Health Service Corps and to revise and extend the programs of assistance under titles VII and VIII of such Act for the education of health professions personnel, and other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 23, 1981

Mr. WAXMAN introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To amend the Public Health Service Act to revise and extend the programs for the National Health Service Corps and to revise and extend the programs of assistance under titles VII and VIII of such Act for the education of health professions personnel, and other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 SHORT TITLE; REFERENCE TO ACT; AND TABLE OF

2 CONTENTS

3 SECTION 1. (a) This Act may be cited as the “Health
4 Professions Educational Assistance and Nurse Training
5 Amendments of 1981”.

(b) Whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

TABLE OF CONTENTS

Sec. 1. Short title; reference to Act; and table of contents.

TITLE I—NATIONAL HEALTH SERVICE CORPS PROGRAMS

Sec. 101. Revision and extension of National Health Service Corps.

Sec. 102. Revision and extension of National Health Service Corps scholarship program.

TITLE II—HEALTH PROFESSIONS PROGRAMS UNDER TITLE VII

PART A—CONSTRUCTION ASSISTANCE

Sec. 201. Repeal of enrollment increase requirement.

Sec. 202. Construction assistance for conversion.

Sec. 203. Loan guarantees and interest subsidies.

PART B—STUDENT ASSISTANCE

Sec. 205. Extension and revision of insured student loan program.

Sec. 206. Extension of student loan program.

Sec. 207. Extension of scholarships for students of exceptional financial need.

PART C—INSTITUTIONAL SUPPORT

- Sec. 211. Grants.
- Sec. 212. Grant requirements.

PART D—PROJECT GRANTS AND CONTRACTS

- Sec. 215. Departments of family medicine.
- Sec. 216. Area health education centers.
- Sec. 217. Physician assistants and dental auxiliaries.
- Sec. 218. General internal medicine and general pediatrics.
- Sec. 219. Family medicine and general practice of dentistry.
- Sec. 220. Assistance to individuals from disadvantaged backgrounds.
- Sec. 221. Start-up, financial distress, conversion, and curriculum grants.

PART E—PUBLIC HEALTH PERSONNEL

- Sec. 230. Institutional support, traineeships, and other programs.
- Sec. 231. Study.

PART F—ALLIED HEALTH PERSONNEL

- Sec. 235. Project grants.
- Sec. 236. Traineeships.
- Sec. 237. Assistance to disadvantaged individuals.
- Sec. 238. Definition.

TITLE III—NURSE TRAINING

- Sec. 301. Construction.
- Sec. 302. Institutional support.
- Sec. 303. Special projects.
- Sec. 304. Advanced nurse training.
- Sec. 305. Nurse practitioner programs.
- Sec. 306. Traineeships.
- Sec. 307. Nurse anesthetists.
- Sec. 308. Student loans.
- Sec. 309. Scholarships.
- Sec. 310. Technical.

TITLE IV—GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY
COMMITTEE

- Sec. 401. Graduate Medical Education National Advisory Committee.

1 **TITLE I—NATIONAL HEALTH SERVICE CORPS**
2 **PROGRAMS**

3 **REVISION AND EXTENSION OF NATIONAL HEALTH**
4 **SERVICE CORPS**

5 **SEC. 101. (a)(1)** Section 331(a)(1) (42 U.S.C.
6 254d(a)(1)) is amended to read as follows: “(1) shall consist
7 of—

8 “(A) such officers of the Regular and Reserve
9 Corps of the Service as the Secretary may designate,

10 “(B) such civilian employees of the United States
11 as the Secretary may appoint, and

12 “(C) such other individuals who are not employ-
13 ees of the United States,

14 (such officers, employees, and individuals hereinafter in this
15 subpart referred to as ‘Corps members’), and”.

16 (2)(A) Section 331(d)(1) is amended by inserting after
17 “each member of the Corps” the following: “(other than a
18 member described in subsection (a)(1)(C))”.

19 (B) Section 331(d) is amended by adding at the end the
20 following:

21 “(3) A member of the Corps described in subparagraph
22 (C) of subsection (a)(1) shall when assigned to an entity under
23 section 333 be subject to the personnel system of such entity,
24 except that such member shall receive during the period of
25 assignment the income that the member would receive if the

1 member was a member of the Corps described in subpara-
2 graph (B) of such subsection.”.

3 (3) Section 331(h)(1) is amended by striking out “, Edu-
4 cation, and Welfare” and inserting in lieu thereof “and
5 Human Services”.

6 (4) Section 331 is amended by redesignating subsections
7 (g) and (h) as subsections (h) and (i), respectively, and by
8 adding after subsection (f) the following new subsection:

9 “(g)(1) The Secretary shall, by rule, prescribe conver-
10 sion provisions applicable to any individual who, within a
11 year after completion of service as a member of the Corps
12 described in subsection (a)(1)(C), becomes a commissioned of-
13 ficer in the Regular or Reserve Corps of the Service.

14 “(2) The rules prescribed under paragraph (1) shall pro-
15 vide that in applying the appropriate provisions of this Act
16 which relate to retirement, any individual who becomes such
17 an officer shall be entitled to have credit for any period of
18 service as a member of the Corps described in subsection
19 (a)(1)(C).”.

20 (b)(1)(A) Section 332(a)(1) (42 U.S.C. 254e(1)) is
21 amended by striking out “which the Secretary determines”
22 each place it occurs and inserting in lieu thereof “which as
23 determined under this section”.

24 (B) Section 332(c) is amended to read as follows:

1 “(c)(1) The Secretary shall refer a proposed designation
2 of an area, population group, or facility (other than a Federal
3 medical facility) to each health systems agency for a health
4 service area which includes such area, group, or facility or if
5 such an area, group, or facility is in a health service area for
6 which a health systems agency has not been designated, to
7 the State health planning and development agency for the
8 State in which the area, group, or facility is located. Each
9 health systems agency and State health planning and devel-
10 opment agency to which a proposed designation has been re-
11 ferred shall be given a reasonable period to review the desig-
12 nation and approve or disapprove the designation. In making
13 such a review the agency shall consider—

14 “(A) the criteria established under subsection (b),

15 “(B) the recommendation of the Governor of each
16 State in which the area, population, or facility under
17 consideration for designation is in whole or part
18 located,

19 “(C) the comments of all interested persons and
20 the comments of the appropriate health professions so-
21 cieties in such area or whose members serve such pop-
22 ulation or facility, and

23 “(D) the extent to which residents of the area,
24 members of the population group, and patients in the
25 facility, who are entitled to have payments made for

1 medical services under title XVIII or XIX of the
2 Social Security Act, cannot obtain such services be-
3 cause of suspension of physicians from the programs
4 under such titles.

5 The reviewing agency shall give written notice to health pro-
6 fessions societies described in subparagraph (C) of the review
7 of a proposed designation, and the societies shall be permit-
8 ted to submit their comments on a proposed designation to
9 the reviewing agency during the ninety-day period beginning
10 on the date the agency notifies it of the review of the pro-
11 posed designation.

12 “(2) Upon completion of its review of a proposed desig-
13 nation, the reviewing agency shall approve or disapprove the
14 designation and submit to the Secretary a detailed statement
15 in writing of the reasons for its decision. If an agency ap-
16 proves a proposed designation, the Secretary shall, within
17 the sixty-day period beginning on the date the Secretary re-
18 ceives the decision of the agency, make the designation
19 unless the Secretary, within such period, determines the deci-
20 sion of the agency is not supported by the criteria established
21 under subsection (b) or the other matters considered by the
22 agency in making its decision and submits to the agency a
23 detailed statement of the reasons for such determination. If
24 an agency disapproves a proposed designation, the Secretary
25 may not make the designation unless the Secretary, within

1 the sixty-day period beginning on the date the Secretary re-
2 ceives the decision of the agency, determines the decision of
3 the agency is not supported by the criteria established under
4 subsection (b) and the other matters considered by the agency
5 in making its decision and submits to the agency a detailed
6 statement of the reasons for such determination.”.

7 (C) Section 332(d) is amended by adding at the end the
8 following: “The revision of a designation shall be subject to
9 the same review and approval and disapproval by health sys-
10 tems agencies and State health planning and development
11 agencies as is prescribed by subsection (c) for designations.”.

12 (D) Section 332(g) is amended by inserting “or the revi-
13 sion of a health manpower shortage area” immediately before
14 the period.

15 (E) The amendments made by this paragraph shall take
16 effect one year after the date of the enactment of this Act.

17 (2)(A) Section 333(b) is amended by adding at the end
18 the following: “Each health systems agency and State health
19 planning and development agency shall in conducting its
20 review under this subsection of an application consider com-
21 ments submitted to the Secretary under subsection (c)(4) re-
22 specting such application.”.

23 (B) Section 333(c) is amended by adding after paragraph
24 (4) the following: “At least ninety days before approving
25 such an application, the Secretary shall provide the appropri-

1 ate health professions societies in the area to which an as-
2 signment would be made under the application the opportuni-
3 ty to submit comments on the assignment.”.

4 (c) Section 332(h) is amended (1) by inserting “(1)”
5 before “to inform”, and (2) by inserting before the period a
6 comma and the following: “and (2) to inform such entities
7 and other individuals and entities who may be interested in
8 the availability of health professions personnel of the provi-
9 sions of section 753 which allow an individual to satisfy a
10 National Health Service Corps Scholarship Program service
11 obligation through the private practice of the individual’s
12 health profession”.

13 (d)(1) Subsection (a) of section 333 (42 U.S.C. 254f) is
14 amended by adding at the end the following:

15 “(3) In approving applications for assignment of mem-
16 bers of the Corps the Secretary shall not discriminate against
17 applications from entities which are not receiving Federal fi-
18 nancial assistance under this Act.”.

19 (2) Effective October 1, 1981, section 333 is amended
20 by redesignating subsections (d) through (h) as subsections (e)
21 through (i), respectively, and by adding after subsection (c)
22 the following new subsection:

23 “(d)(1) The Secretary may not approve an application
24 for the assignment of a member of the Corps described in
25 subparagraph (C) of section 331(a)(1) to an entity unless the

1 application of the entity contains assurances satisfactory to
2 the Secretary that the entity (A) has sufficient financial re-
3 sources to provide the member of the Corps with an income
4 of not less than the income to which the member would be
5 entitled if the member was a member described in subpara-
6 graph (B) of section 331(a)(1), or (B) would have such finan-
7 cial resources if a grant was made to the entity under para-
8 graph (2).

9 “(2)(A) If in approving an application of an entity for
10 the assignment of a member of the Corps described in sub-
11 paragraph (C) of section 331(a)(1) the Secretary determines
12 that the entity does not have sufficient financial resources to
13 provide the member of the Corps with an income of not less
14 than the income to which the member would be entitled if the
15 member was a member described in subparagraph (B) of sec-
16 tion 331(a)(1), the Secretary may make a grant to the entity
17 to assure that the member of the Corps assigned to it will
18 receive during the period of assignment to the entity such an
19 income.

20 “(B) The amount of any grant under subparagraph (A)
21 shall be determined by the Secretary. Payments under such a
22 grant may be made in advance or by way of reimbursement,
23 and at such intervals and on such conditions, as the Secre-
24 tary finds necessary. No grant may be made unless an appli-
25 cation therefor is submitted to and approved by the Secre-

1 tary. Such an application shall be in such form, submitted in
2 such manner, and contain such information, as the Secretary
3 shall by regulation prescribe.”.

4 (3) Subsection (g) (as so redesignated) of section 333 is
5 amended by adding at the end of paragraph (1) the following:
6 “Assistance provided under this paragraph shall include as-
7 sistance to an entity in (A) analyzing the potential use of
8 health professions personnel in defined health services deliv-
9 ery areas by the residents of such areas, (B) determining the
10 need for such personnel in such areas, (C) determining the
11 extent to which such areas will have a financial base to sup-
12 port the practice of such personnel and the extent to which
13 additional financial resources are needed to adequately sup-
14 port the practice, and (D) determining the types of inpatient
15 and other health services that should be provided by such
16 personnel in such areas.”.

17 (4) Subsection (g) (as so redesignated) of section 333 is
18 amended by adding at the end the following:

19 “(4)(A) The Secretary shall undertake to demonstrate
20 the improvements that can be made in the assignment of
21 members of the Corps to health manpower shortage areas
22 and in the delivery of health care by Corps members in such
23 areas through coordination with States, political subdivisions
24 of States, agencies of States and political subdivisions, and
25 other public and nonprofit private entities which have exper-

1 tise in the planning, development, and operation of centers
2 for the delivery of primary health care. In carrying out this
3 subparagraph, the Secretary shall enter into agreements with
4 qualified entities which provide that if—

5 “(i) the entity places in effect a program for the
6 planning, development, and operation of centers for the
7 delivery of primary health care in health manpower
8 shortage areas which reasonably addresses the need for
9 such care in such areas, and

10 “(ii) under the program the entity will perform the
11 functions described in subparagraph (B),
12 the Secretary will assign under this section members of the
13 Corps in accordance with the program.

14 “(B) For purposes of subparagraph (A), the term ‘quali-
15 fied entity’ means a State, political subdivision of a State, an
16 agency of a State or political subdivision, or other public or
17 nonprofit private entity operating solely within one State,
18 which the Secretary determines is able—

19 “(i) to analyze the potential use of health profes-
20 sions personnel in defined health services delivery
21 areas by the residents of such areas;

22 “(ii) to determine the need for such personnel in
23 such areas and to recruit, select, and retain health pro-
24 fessions personnel (including members of the National
25 Health Service Corps) to meet such need;

1 “(iii) to determine the extent to which such areas
2 will have a financial base to support the practice of
3 such personnel and the extent to which additional fi-
4 nancial resources are needed to adequately support the
5 practice;

6 “(iv) to determine the types of inpatient and other
7 health services that should be provided by such person-
8 nel in such areas;

9 “(v) to assist such personnel in the development
10 of their clinical practice and fee schedules and in the
11 management of their practice;

12 “(vi) to assist in the planning and development of
13 facilities for the delivery of primary health care; and

14 “(vii) to assist in establishing the governing bodies
15 of centers for the delivery of such care and to assist
16 such bodies in defining and carrying out their responsi-
17 bilities.”.

18 (e)(1) Section 334(a) (42 U.S.C. 254g(a)) is amended by
19 inserting “for the assignment of a member of the Corps”
20 after “section 333”.

21 (2) Section 334(a)(3)(A) is amended by inserting “from
22 the United States” after “received by such member”.

23 (3) Section 334(a)(3)(C) is amended (A) by inserting “or
24 a grant under section 333(d)(2)” after “section 335(c)”, and

1 (B) by inserting “or grant” after “such loan” each time it
2 occurs.

3 (4) Section 334(b) is amended by adding at the end the
4 following:

5 “(4) In determining whether to grant a waiver under
6 paragraph (1) or (2), the Secretary shall not discriminate
7 against a public entity.”.

8 (5) Subsection (e) of section 334 is amended to read as
9 follows:

10 “(e)(1) There is established in the Treasury of the
11 United States a revolving fund to be called the National
12 Health Service Corps Fund (hereinafter in this subsection re-
13 ferred to as the ‘Fund’) which shall be available to the Secre-
14 tary, without fiscal year limitation, to carry out this subpart.

15 “(2) There shall be deposited in the Fund, subject to
16 withdrawal by check by the Secretary—

17 “(A) funds received by the Secretary after Sep-
18 tember 30, 1981, under an agreement entered into
19 under subsection (a), and

20 “(B) interest which may be earned on investments
21 of the Fund.

22 “(3) If the Secretary determines that the moneys of the
23 Fund are in excess of current needs, the Secretary may re-
24 quest the investment of such amounts as the Secretary deems
25 advisable by the Secretary of the Treasury in obligations of,

1 or obligations guaranteed by, the Government of the United
2 States, and, with the approval of the Secretary of the Treas-
3 ury, in such other obligations or securities as it deems
4 appropriate.

5 “(4) With the approval of the Secretary of the Treasury,
6 the Secretary of Health and Human Services may deposit
7 moneys in the Fund in any Federal Reserve bank, any de-
8 pository for public funds, or in such other places and in such
9 manner as the Secretary of Health and Human Services and
10 the Secretary of the Treasury may mutually agree.

11 “(5) The Fund and the funds credited to it shall not be
12 subject to apportionment under section 3679 of the Revised
13 Statutes (31 U.S.C. 665).”.

14 (f)(1) Effective October 1, 1981, subpart II of part D of
15 title III is amended by redesignating sections 336, 337, and
16 338 as sections 338, 338A, and 338B, respectively; by trans-
17 ferring section 755 to the subpart, inserting such section
18 after section 335, and redesignating it as section 336; and by
19 adding after section 336 (as so redesignated) the following
20 new section:

21 “PREPARATION FOR PRACTICE

22 “SEC. 337. (a) The Secretary may make grants to and
23 enter into contracts with public and private nonprofit entities
24 for the conduct of programs which are designed to prepare
25 individuals subject to a service obligation under the National

1 Health Service Corps scholarship program to effectively pro-
2 vide health services in the health manpower shortage area to
3 which they are assigned.

4 “(b) No grant may be made or contract entered into
5 under subsection (a) unless an application therefor is submit-
6 ted to and approved by the Secretary. Such an application
7 shall be in such form, submitted in such manner, and contain
8 such information, as the Secretary shall by regulation
9 prescribe.”.

10 (2) Subsection (a)(1) of section 336 (as so redesignated)
11 is amended by inserting “at least two years of” after
12 “completed”.

13 (g) Section 338B(a) (as so redesignated) (42 U.S.C.
14 254k) is amended (1) by striking out “and” after “1979;”,
15 and (2) by adding before the period a semicolon and the fol-
16 lowing: “\$145,000,000 for the fiscal year ending September
17 30, 1982; \$205,000,000 for the fiscal year ending September
18 30, 1983; and \$265,000,000 for the fiscal year ending Sep-
19 tember 30, 1984”.

20 (h) Effective October 1, 1981, the Secretary of Health
21 and Human Services shall—

22 (1) evaluate the criteria used under section 332(b)
23 of the Public Health Service Act to determine if the
24 use of the criteria has resulted in areas which do not

1 have a shortage of health professions personnel being
2 designated as health manpower shortage areas; and

3 (2) consider different criteria (including the actual
4 use of health professions personnel in an area by the
5 residents of an area taking into account their health
6 status) which may be used to designate health man-
7 power shortage areas.

8 Not later than April 1, 1983, the Secretary shall report to
9 the Congress the results of the activities undertaken under
10 this subsection.

11 REVISION AND EXTENSION OF NATIONAL HEALTH

12 SERVICE CORPS SCHOLARSHIP PROGRAM

13 SEC. 102. (a)(1) Paragraphs (1) through (4) of section
14 752(b) (42 U.S.C. 294u(b)) are amended to read as follows:

15 “(b)(1) If an individual is required under subsection (a)
16 to provide service as specified in section 751(f)(1)(B)(iv)
17 (hereinafter in this subsection referred to as ‘obligated serv-
18 ice’), the Secretary shall, not later than ninety days before
19 the date described in paragraph (5), determine if the individu-
20 al shall provide such service—

21 “(A) as a member of the Corps who is a commis-
22 sioned officer in the Regular or Reserve Corps of the
23 Service or who is a civilian employee of the United
24 States, or

1 “(B) as a member of the Corps who is not such
2 an officer or employee,
3 and shall notify such individual of such determination.

4 “(2) If the Secretary determines that an individual shall
5 provide obligated service as a member of the Corps who is a
6 commissioned officer in the Service or a civilian employee of
7 the United States, the Secretary shall, not later than sixty
8 days before the date described in paragraph (5), provide such
9 individual with sufficient information regarding the advan-
10 tages and disadvantages of service as such a commissioned
11 officer or civilian employee to enable the individual to make a
12 decision on an informed basis. To be eligible to provide obli-
13 gated service as a commissioned officer in the Service, an
14 individual shall notify the Secretary, not later than thirty
15 days before the date described in paragraph (5), of the indi-
16 vidual's desire to provide such service as such an officer. If
17 an individual qualifies for an appointment as such an officer,
18 the Secretary shall, as soon as possible after the date de-
19 scribed in paragraph (5), appoint the individual as a commis-
20 sioned officer of the Regular or Reserve Corps of the Service
21 and shall designate the individual as a member of the Corps.

22 “(3) If an individual provided notice by the Secretary
23 under paragraph (2) does not qualify for appointment as a
24 commissioned officer in the Service, the Secretary shall, as
25 soon as possible after the date described in paragraph (5),

1 appoint such individual as a civilian employee of the United
2 States and designate the individual as a member of the
3 Corps.

4 “(4) If the Secretary determines that an individual shall
5 provide obligated service as a member of the Corps who is
6 not an employee of the United States, the Secretary shall, as
7 soon as possible after the date described in paragraph (5),
8 designate such individual as a member of the Corps to pro-
9 vide such service.”.

10 (2)(A) Subsection (c)(1) of section 752 is amended by
11 striking out “or as a member of the Corps” and inserting in
12 lieu thereof “or is designated as a member of the Corps under
13 subsection (b)(3) or (b)(4)”.

14 (B) The second sentence of subsection (d) of section 752
15 is amended by inserting after “written contract” the follow-
16 ing: “and if such individual is an officer in the Service or a
17 civilian employee of the United States”.

18 (b) Subsection (e) of section 752 is amended to read as
19 follows:

20 “(e) Notwithstanding any other provision of this title,
21 service of an individual under a National Research Service
22 Award awarded under subparagraph (A) or (B) of section
23 472(a)(1) shall be counted against the period of obligated
24 service which the individual is required to perform under the
25 scholarship program.”.

1 (c)(1) Section 753(b)(1)(B) (42 U.S.C. 294v(b)(1)(B)) is
2 amended (A) by inserting "(i)" before "shall not", and (B) by
3 inserting before the semicolon a comma and the following:
4 "and (ii) shall agree to accept an assignment under section
5 1842(b)(3)(B)(ii) of such Act for all services for which pay-
6 ment may be made under part B of title XVIII of such Act
7 and enter into an appropriate agreement with the State
8 agency which administers the State plan for medical assist-
9 ance under title XIX of such Act to provide services to indi-
10 viduals entitled to medical assistance under the plan".

11 (2) Section 753 is amended by adding the following new
12 subsections:

13 "(c) If an individual breaches the contract entered into
14 under section 751 by failing (for any reason) to begin his
15 service obligation in accordance with an agreement entered
16 into under subsection (a) or to complete such service obliga-
17 tion, the Secretary may permit such individual to perform
18 such service obligation as a member of the Corps.

19 "(d) The Secretary shall, upon request, provide techni-
20 cal assistance to individuals who are considering entering
21 into an agreement under subsection (a) or have entered into
22 such an agreement to assist them in the establishment of
23 their clinical practice under the agreement."

24 (3) Section 751(c)(2) is amended by inserting "informa-
25 tion respecting meeting a service obligation through private

1 practice under an agreement under section 753 and" after
2 "(2)".

3 (4)(A) Subsection (a) of section 753 is amended by in-
4 serting "or under section 225 (as in effect on September 30,
5 1977)" after "section 752(a)".

6 (B) Section 754(c) (42 U.S.C. 294w(c)) is amended (i)
7 by striking out "(c) If" and inserting in lieu thereof "(c)(1)
8 Except as provided in paragraph (2), if", and (ii) by adding at
9 the end the following:

10 "(2) If an individual is released under section 753 from
11 a service obligation under section 225 (as in effect on Sep-
12 tember 30, 1977) and if the individual does not meet the
13 service obligation incurred under section 753, subsection (f)
14 of such section 225 shall apply to such individual in lieu of
15 paragraph (1) of this subsection."

16 (C) Section 735(c)(1) (42 U.S.C. 294h(c)(1)) is amended
17 by striking out "clauses (A) and (B) of".

18 (d) Section 751(a) is amended by inserting "clinical psy-
19 chologists," after "pharmacists,".

20 (e) Section 751(d) is amended by inserting after para-
21 graph (2) the following: "In considering applications and con-
22 tracts for which a priority is required under paragraph (2),
23 the Secretary shall give special consideration to the applica-
24 tions and contracts of individuals who intend to be primary
25 care physicians in health manpower shortage areas (as de-

1 fined in section 332), who have resided or been employed in
2 such areas, and who meet such other qualifications as the
3 Secretary may prescribe to assist in determining if an individ-
4 ual will become a primary care physician in such an area.”.

5 (f)(1) The first sentence of section 756(a) is amended (A)
6 by striking out “and” after “1979,” and (B) by inserting
7 before the period a comma and the following: “\$101,000,000
8 for the fiscal year ending September 30, 1982, \$109,000,000
9 for the fiscal year ending September 30, 1983, and
10 \$117,000,000 for the fiscal year ending September 30,
11 1984”.

12 (2) The second sentence of such section is amended (A)
13 by striking out “1981” and inserting in lieu thereof “1985”,
14 and (B) by striking out “1980” and inserting in lieu thereof
15 “1984”.

16 (g) The amendments made by subsection (a) shall apply
17 with respect to contracts entered into under the National
18 Health Service Corps scholarship program under subpart III
19 of part C of title VII of the Public Health Service Act after
20 the date of the enactment of this Act. An individual who
21 before such date has entered into such a contract and who
22 has not begun the period of obligated service required under
23 such contract shall be given the opportunity to revise such
24 contract to permit the individual to serve such period as a

1 member of the National Health Service Corps who is not an
2 employee of the United States.

3 TITLE II—HEALTH PROFESSIONS PROGRAMS

4 UNDER TITLE VII

5 PART A—CONSTRUCTION ASSISTANCE

6 REPEAL OF ENROLLMENT INCREASE REQUIREMENT

7 SEC. 201. (a) Paragraph (2) of section 721(c) (42 U.S.C.
8 293a(c)(2)) is amended (1) by inserting “and” after “the fa-
9 cility,”, and (2) by striking out “, and (D)” and all that fol-
10 lows in that paragraph and inserting in lieu thereof a semi-
11 colon.

12 (b) The amendment made by subsection (a) shall apply
13 with respect to any entity which received a grant under sec-
14 tion 720 of the Public Health Service Act irrespective of the
15 date of the grant.

16 CONSTRUCTION ASSISTANCE FOR CONVERSIONS

17 SEC. 202. (a) Section 720(a) (42 U.S.C. 293(a)) is
18 amended by adding at the end the following:

19 “(3) The Secretary may make grants to schools provid-
20 ing the first two years of education leading to the degree of
21 doctor of medicine to assist in the construction of the teach-
22 ing facilities which the schools require to become schools of
23 medicine.”.

24 (b) Subsection (b) of such section is amended to read as
25 follows:

1 “(b) For the purpose of grants under subsection (a)(3),
2 there are authorized to be appropriated \$15,000,000 for the
3 fiscal year ending September 30, 1982, to remain available
4 until expended.”.

5 (c) Section 721(b)(1) (42 U.S.C. 293a(b)) is amended (1)
6 by inserting after “(1)” the following: “To be eligible to
7 apply for a grant under section 720(a)(3) the applicant must
8 be a public or nonprofit school providing the first two years of
9 education leading to the degree of doctor of medicine and be
10 accredited by a recognized body or bodies approved for such
11 purpose by the Secretary of Education.”, and (2) by striking
12 out “under this part” and inserting in lieu thereof “under
13 paragraph (1) or (2) of section 720(a)”.

14 (d) Subsection 721(g)(1) is amended by striking out
15 “section 720(a)(2)” and inserting in lieu thereof “paragraph
16 (2) or (3) of section 720(a)”.

17 (e) Subsection (a) of section 722 (42 U.S.C. 293b(a)) is
18 amended by adding at the end the following:

19 “(3) The amount of any grant under section 720(a)(3)
20 shall be such amount as the Secretary determines to be ap-
21 propriate after obtaining advice from the Council, except that
22 no grant for any project may exceed 80 percent of the neces-
23 sary costs of construction, as determined by the Secretary.”.

1 (f) Section 723(a) (42 U.S.C. 293c(a)) is amended by
 2 striking out "section 720(a)(1)" and inserting in lieu thereof
 3 "paragraph (1) or (3) of section 720(a)".

4 LOAN GUARANTEES AND INTEREST SUBSIDIES

5 SEC. 203. (a) Section 726(a) (42 U.S.C. 293i(a)) is
 6 amended (1) by striking out "construction projects for" in the
 7 first sentence and inserting in lieu thereof "projects for the
 8 remodeling, renovation, or alteration of", (2) by striking out
 9 "1980" and inserting in lieu thereof "1984", and (3) by
 10 striking out "cost of the construction of the project" in the
 11 last sentence and inserting in lieu thereof "cost of the project,
 12 including architect fees and the initial equipment of the re-
 13 modeled, renovated, or altered teaching facilities".

14 (b) Section 726(b) is amended (1) by inserting "before
 15 October 1, 1981," after "loan has been made", and (2) by
 16 striking out ", during the period beginning July 1, 1971, and
 17 ending with the close of September 30, 1980,".

18 PART B—STUDENT ASSISTANCE

19 EXTENSION AND REVISION OF INSURED STUDENT LOAN

20 PROGRAM

21 SEC. 205. (a)(1) The first sentence of section 728(a) (42
 22 U.S.C. 294a(a)) is amended by striking out "and for the next
 23 fiscal year" and inserting in lieu thereof "and for each of the
 24 next four fiscal years".

1 (2) The second sentence of such section is amended by
2 striking out "1982" and inserting in lieu thereof "1986".

3 (b) Section 728(c) is amended by striking out the period
4 at the end and inserting in lieu thereof a comma and the
5 following: "except that if any loan made under this subpart is
6 included in a consolidated loan pursuant to the authority of
7 the Association under part B of title IV of the Higher Educa-
8 tion Act of 1965, the interest rate on such consolidated loan
9 shall be set at the weighted average interest rate of all loans
10 offered for consolidation and the resultant per centum shall
11 be rounded downward to the nearest one-eighth of 1 per
12 centum, except that the interest rate shall be no less than the
13 applicable interest rate of the guaranteed student loan pro-
14 gram established under part B of title IV of the Higher Edu-
15 cation Act of 1965. In the case of such a consolidated loan,
16 the borrower shall be responsible for any interest which ac-
17 crues prior to the beginning of the repayment period of the
18 loan, or which accrues during a period in which principal
19 need not be paid (whether or not such principal is in fact
20 paid) by reason of any provision of the Higher Education Act
21 of 1965. Special allowances payable with respect to consoli-
22 dated loans made by the Association pursuant to the terms of
23 this subsection—

24 “(1) shall be computed in accordance with section
25 438(b)(2)(A) of the Higher Education Act of 1965, and

1 “(2) shall be reduced (A) by subtracting 7 percent
2 from the weighted average interest rate of a loan com-
3 puted according to this subsection, and (B) by subtract-
4 ing the resultant remainder from such special allow-
5 ance.”

6 (c) Section 729(a) (42 U.S.C. 294b(a)) is amended (1) by
7 striking out “\$15,000” and inserting in lieu thereof
8 “\$20,000”, and (2) by striking out “\$60,000” and inserting
9 in lieu thereof “\$80,000”.

10 (d)(1) Section 731(a)(2) is amended (A) by striking out
11 “installments of principal need not be paid, but interest shall
12 accrue and be paid” in subparagraph (C) and inserting in lieu
13 thereof “installments of principal and interest need not be
14 paid, but interest shall accrue”, (B) by striking out “three
15 years” in subparagraph (C)(ii) and inserting in lieu thereof
16 “four years”, (C) by inserting “except as provided in subpar-
17 agraph (C)” after “period of the loan” in subparagraph (D),
18 and (D) by striking out “otherwise payable (i) before the be-
19 ginning of the repayment period, (ii) during any period de-
20 scribed in subparagraph (C), or (iii) during any other period of
21 forbearance of payment of principal,” in subparagraph (D).

22 (2) Section 731(a)(2) is amended (A) by redesignating
23 subparagraphs (E) and (F) as subparagraphs (F) and (G), re-
24 spectively, and (B) by inserting after subparagraph (D) the
25 following:

1 “(E) offers, in accordance with criteria pre-
2 scribed by regulation by the Secretary, a schedule
3 for repayment of principal and interest under
4 which payment of a portion of the principal and
5 interest otherwise payable at the beginning of the
6 repayment period (as defined in such regulations)
7 is deferred until a later time in the period;”.

8 (3) Section 731(c) is amended by striking out “The
9 total” and inserting in lieu thereof “Except as provided in
10 subsection (a)(2)(C), the total”.

11 (e) Paragraph (1) of section 737 (42 U.S.C. 294j(1)) is
12 amended to read as follows:

13 “(1) The term ‘eligible institution’ means a school of
14 medicine, osteopathy, dentistry, veterinary medicine, optom-
15 etry, pharmacy, podiatry, or public health within the United
16 States which is accredited by a recognized body or bodies
17 approved for such purpose by the Secretary of Education.”.

18 (f)(1) Section 739(b) is amended to read as follows:

19 “(b) The Secretary shall require an eligible institution to
20 record, and to make available to the lender and to the Secre-
21 tary upon request, the name, address, postgraduate destina-
22 tion, and other reasonable identifying information for each
23 student of such institution who has a loan insured under this
24 subpart.”.

1 (2) Section 731(a)(1)(A) (42 U.S.C. 294d(a)(1)(A)) is
 2 amended (A) by striking out clause (iii), and (B) by redesignig-
 3 nating clauses (iv), (v), and (vi) as clauses (iii), (iv), and (v),
 4 respectively.

5 EXTENSION OF STUDENT LOAN PROGRAM

6 SEC. 206. (a)(1) The first sentence of section 742(a) (42
 7 U.S.C. 294b(a)) is amended (1) by striking out "and" after
 8 "1979," and (2) by inserting before the period a comma and
 9 the following: "\$22,500,000 for the fiscal year ending Sep-
 10 tember 30, 1982, \$25,000,000 for the fiscal year ending
 11 September 30, 1983, and \$27,500,000 for the fiscal year
 12 ending September 30, 1984".

13 (2) The second sentence of such section is amended (A)
 14 by striking out "1981" and inserting in lieu thereof "1985",
 15 and (B) by striking out "1980" and inserting in lieu thereof
 16 "1984".

17 (b) Section 743 (42 U.S.C. 294c) is amended by striking
 18 out "1983" each place it occurs and inserting in lieu thereof
 19 "1987".

20 EXTENSION OF SCHOLARSHIPS FOR STUDENTS OF

21 EXCEPTIONAL FINANCIAL NEED

22 SEC. 207. (a) Section 758(d) (42 U.S.C. 294z(d)) is
 23 amended (1) by striking out "and" after "1979," and (2) by
 24 inserting before the period a comma and the following:
 25 "\$40,000,000 for the fiscal year ending September 30, 1982,

1 \$50,000,000 for the fiscal year ending September 30, 1983,
 2 and \$60,000,000 for the fiscal year ending September 30,
 3 1984”.

4 (b) Section 758(c) is amended (1) by striking out “dis-
 5 tribute grants under this section among all schools of the
 6 health professions, but shall”, and (2) by striking out “such
 7 grants” and inserting in lieu thereof “grants under subsection
 8 (a)”.

9 (c)(1) Section 758(a) is amended by striking out “first
 10 year” and inserting in lieu thereof “first or second year”.

11 (2) Section 758(b)(1) is amended by striking out “first
 12 year” and inserting in lieu thereof “first or second year”.

13 (3) Section 758(b)(3) is amended (A) by striking out
 14 “first year of study” and inserting in lieu thereof “first or
 15 second year of study”, and (B) by striking out “student’s first
 16 year” and inserting in lieu thereof “student’s first or second
 17 year.”

18 PART C—INSTITUTIONAL SUPPORT

19 GRANTS

20 SEC. 211. (a) Effective with respect to fiscal years be-
 21 ginning after September 30, 1981, section 770(a) (42 U.S.C.
 22 295f(a)) is amended to read as follows:

23 “SEC. 770. (a) GRANT COMPUTATION.—The Secretary
 24 shall make annual grants to schools of medicine, osteopathy,
 25 dentistry, veterinary medicine, optometry, pharmacy, and po-

1 diatry for the support of the education programs of such
2 schools. The amount of the annual grant to each such school
3 with an approved application shall be computed for each
4 fiscal year as follows:

5 “(1) Each school of medicine, osteopathy, and
6 dentistry shall receive—

7 “(A) for the fiscal year ending September 30,
8 1982, \$1,000 for each full-time student enrolled
9 in such school in the school year beginning in
10 such fiscal year; and

11 “(B) for the fiscal year ending September 30,
12 1983, \$500 for each full-time student enrolled in
13 such school in the school year beginning in such
14 fiscal year.

15 “(2) Each school of veterinary medicine shall
16 receive—

17 “(A) for the fiscal year ending September 30,
18 1982, \$600 for each full-time student enrolled in
19 such school in the school year beginning in such
20 fiscal year; and

21 “(B) for the fiscal year ending September 30,
22 1983, \$300 for each full-time student enrolled in
23 such school in the school year beginning in such
24 fiscal year.

25 “(3) Each school of optometry shall receive—

1 “(A) for the fiscal year ending September 30,
2 1982, \$350 for each full-time student enrolled in
3 such school in the school year beginning in such
4 fiscal year; and

5 “(B) for the fiscal year ending September 30,
6 1983, \$100 for each full-time student enrolled in
7 such school in the school year beginning in such
8 fiscal year.

9 “(4) Each school of pharmacy shall receive—

10 “(A) for the fiscal year ending September 30,
11 1982, \$300 for each full-time student enrolled in
12 the last four years of such school in the school
13 year beginning in such fiscal year; and

14 “(B) for the fiscal year ending September 30,
15 1983, \$100 for each full-time student enrolled in
16 the last four years of such school in the school
17 year beginning in such fiscal year.

18 “(5) Each school of podiatry shall receive—

19 “(A) for the fiscal year ending September 30,
20 1982, \$400 for each full-time student enrolled in
21 such school in the school year beginning in such
22 fiscal year; and

23 “(B) for the fiscal year ending September 30,
24 1983, \$200 for each full-time student enrolled in

1 such school in the school year beginning in such
2 fiscal year.”.

3 (b)(1) Section 770(b) is amended by striking out “public
4 health,”.

5 (2) Section 770(c)(2) is amended by striking out “, or to
6 a graduate degree in public health or an equivalent degree”.

7 (3) Subsection (d) of section 770 is repealed and subsec-
8 tion (e) is redesignated as subsection (d).

9 (4) Section 772(b)(1) is amended by striking out “public
10 health,”.

11 (c) Effective with respect to fiscal years beginning after
12 September 30, 1981, section 770(d) (as so redesignated) is
13 amended to read as follows:

14 “(d) AUTHORIZATIONS OF APPROPRIATIONS.—

15 “(1) There are authorized to be appropriated
16 \$24,836,000 for the fiscal year ending September 30,
17 1982, and \$12,418,000 for the fiscal year ending Sep-
18 tember 30, 1983, for payments under grants under this
19 section to schools of medicine.

20 “(2) There are authorized to be appropriated
21 \$1,936,000 for the fiscal year ending September 30,
22 1982, and \$968,000 for the fiscal year ending Septem-
23 ber 30, 1983, for payments under grants under this
24 section for schools of osteopathy.

1 “(3) There are authorized to be appropriated
2 \$8,099,000 for the fiscal year ending September 30,
3 1982, and \$4,049,000 for the fiscal year ending Sep-
4 tember 30, 1983, for payments under grants under this
5 section for schools of dentistry.

6 “(4) There are authorized to be appropriated
7 \$1,800,000 for the fiscal year ending September 30,
8 1982, and \$900,000 for the fiscal year ending Septem-
9 ber 30, 1983, for payments under grants under this
10 section to schools of veterinary medicine.

11 “(5) There are authorized to be appropriated
12 \$529,000 for the fiscal year ending September 30,
13 1982, and \$265,000 for the fiscal year ending Septem-
14 ber 30, 1983, for payments under grants under this
15 section to schools of optometry.

16 “(6) There are authorized to be appropriated
17 \$3,025,000 for the fiscal year ending September 30,
18 1982, and \$1,513,000 for the fiscal year ending Sep-
19 tember 30, 1983, for payments under grants under this
20 section to schools of pharmacy.

21 “(7) There are authorized to be appropriated
22 \$406,000 for the fiscal year ending September 30,
23 1982, and \$203,000 for the fiscal year ending Septem-
24 ber 30, 1983, for payments under grants under this
25 section to schools of podiatry.”.

1 (d)(1) The heading for part E of title VII is amended by
2 striking out "PUBLIC HEALTH,".

3 (2) The heading for section 770 is amended to read as
4 follows:

5 "INSTITUTIONAL SUPPORT".

6 (e) Section 700 is repealed.

7 GRANT REQUIREMENTS

8 SEC. 212. (a)(1) Effective with respect to grants made
9 under section 770 of the Public Health Service Act for the
10 fiscal year ending September 30, 1980, section 771(a)(1) (42
11 U.S.C. 295f-1(a)(1)) is amended by inserting after "first-year
12 enrollment" the following: "(determined without regard to
13 any increase in such enrollment made by the school to enable
14 it to qualify for financial assistance under chapter 82 of title
15 38, United States Code)".

16 (2) Effective with respect to grants made under section
17 770 of the Public Health Service Act for fiscal years begin-
18 ning after September 30, 1981, subsection (a) of section 771
19 (42 U.S.C. 295f-1) is amended to read as follows:

20 "SEC. 771. (a) IN GENERAL.—

21 "(1) The Secretary shall not make a grant under
22 section 770(a) to any school in a fiscal year beginning
23 after September 30, 1981, unless the application for
24 the grant contains, or is supported by, assurances sat-
25 isfactory to the Secretary that the applicant will

1 expend in carrying out its functions as a school of
2 medicine, osteopathy, dentistry, veterinary medicine,
3 optometry, pharmacy, or podiatry, as the case may be,
4 during the fiscal year for which such grant is sought,
5 an amount of funds (other than funds for construction
6 as determined by the Secretary) from non-Federal
7 sources which is at least as great as the amount of
8 funds expended by such applicant for such purpose (ex-
9 cluding expenditures of a nonrecurring nature) in the
10 fiscal year preceding the fiscal year for which such
11 grant is sought.

12 “(2) If in any fiscal year the amount appropriated
13 under subsection (d) of section 770 for grants under
14 subsection (a) of such section for a category of schools
15 is less than the amount appropriated for the fiscal year
16 ending September 30, 1981, for such grants, then in
17 the fiscal year in which the appropriations are less, no
18 grant may be made under subsection (a) of section 770
19 to any school in such category which did not receive
20 such a grant in the fiscal year ending September 30,
21 1981. For purposes of this paragraph, a school of
22 pharmacy which did not receive such a grant in such
23 fiscal year because accreditation requirements prevent-
24 ed it from meeting applicable enrollment requirements

1 shall be considered as having received such a grant in
2 such fiscal year.”.

3 (b)(1) Subsection (b)(1) of section 771 is amended by
4 striking out “paragraphs (2) and (3)” and inserting in lieu
5 thereof “paragraph (2)”.

6 (2) Paragraph (3) of section 771(b) is repealed.

7 (c) Subsection (g)(3) of section 771 is amended by strik-
8 ing out “(or 50 percent if the applicant is a nonprofit private
9 school of optometry)”.

10 (d) Subsection (e) of section 771 is repealed and subsec-
11 tions (f), (g), (h), and (i) are redesignated as subsections (e),
12 (f), (g), and (h), respectively.

13 (e)(1) Subsection (b) of section 772 (42 U.S.C. 295f-5)
14 is amended by striking out “or subsection (a) or (b) of section
15 788”.

16 (2) Paragraph (2) of subsection (d) of section 772 is
17 amended by striking out “under the section authorizing the
18 grant for which the application is made” and inserting in lieu
19 thereof “under section 770”.

20 (3) The first sentence of section 788(a)(3) (42 U.S.C.
21 295g-8(a)(3)) is amended by inserting “and the applicant
22 meets the requirements of subsection (b) of section 772”
23 before the period.

24 (f)(1) The heading for section 771 is amended to read as
25 follows:

1 "ELIGIBILITY FOR INSTITUTIONAL SUPPORT".

2 (2) The heading for section 772 is amended to read as
3 follows:

4 "APPLICATIONS FOR INSTITUTIONAL SUPPORT".

5 PART D—PROJECT GRANTS AND CONTRACTS

6 DEPARTMENTS OF FAMILY MEDICINE

7 SEC. 215. (a) Section 780(c) (42 U.S.C. 295g(c)) is
8 amended (1) by striking out "and" after "1979," and (2) by
9 inserting after "1980" a comma and the following:
10 "\$20,000,000 for the fiscal year ending September 30, 1982,
11 \$25,000,000 for the fiscal year ending September 30, 1983,
12 and \$30,000,000 for the fiscal year ending September 30,
13 1984".

14 (b) Section 780(b)(1)(D) is amended by striking out
15 "have control over" and inserting in lieu thereof "have con-
16 trol over or affiliation with".

17 AREA HEALTH EDUCATION CENTERS

18 SEC. 216. (a) Section 781(g) (42 U.S.C. 295g-1(g)) is
19 amended (1) by striking out "and" after "1979," and (2) by
20 inserting after "1980, " the following: "\$28,000,000 for the
21 fiscal year ending September 30, 1982, \$30,000,000 for the
22 fiscal year ending September 30, 1983, and \$32,000,000 for
23 the fiscal year ending September 30, 1984,".

1 (b) The last sentence of section 781(c) is amended by
2 striking out "paragraph (3)" and inserting in lieu thereof
3 "paragraph (2) or (3)".

4 (c) Section 781(d)(2)(E) is amended by striking out
5 "support services" and inserting in lieu thereof "educational
6 support services".

7 (d)(1) Effective October 1, 1981, subsection (a) of sec-
8 tion 781 is amended to read as follows:

9 "SEC. 781. (a)(1) The Secretary may enter into con-
10 tracts with schools of medicine and osteopathy for the plan-
11 ning, development, and operation of area health education
12 center programs.

13 "(2) The Secretary may enter into contracts with
14 schools of medicine and osteopathy, which have previously
15 received Federal financial assistance for an area health edu-
16 cation center program under section 802 of Public Law
17 94-484 or this section, to carry out under area health educa-
18 tion center programs—

19 "(A) projects to improve the distribution, supply,
20 quality, utilization, and efficiency of health personnel in
21 the health services delivery system;

22 "(B) projects to encourage the regionalization of
23 educational responsibilities of the health professions
24 schools; and

1 “(C) projects designed to prepare, through precep-
 2 torships and other programs, individuals subject to a
 3 service obligation under the National Health Service
 4 Corps scholarship program to effectively provide health
 5 services in health manpower shortage areas.”.

6 (2) The first sentence of subsection (e) is repealed.

7 (3) The first sentence of subsection (f) is amended to
 8 read as follows: “For purposes of this section, the term ‘area
 9 health education center program’ means a program which is
 10 organized as provided in subsection (b) and under which the
 11 participating medical and osteopathic schools and the area
 12 health education centers meet the requirements of subsec-
 13 tions (c) and (d).”.

14 (4) Subsection (g) of such section is amended by adding
 15 at the end the following: “The Secretary may obligate not
 16 more than 10 percent of the amount appropriated under this
 17 subsection for any fiscal year for contracts under subsection
 18 (a)(2).”.

19 (e) The authority to enter into contracts under section
 20 781 of the Public Health Service Act is not authority to
 21 enter into cooperative agreements under that section.

22 PHYSICIAN ASSISTANTS AND DENTAL AUXILIARIES

23 SEC. 217. (a) Section 783(e) (42 U.S.C. 295g-3(e)) is
 24 amended (1) by striking out “and” after “1979,”, and (2) by
 25 inserting after “1980” a comma and the following:

1 "\$15,000,000 for the fiscal year ending September 30, 1982,
 2 \$16,000,000 for the fiscal year ending September 30, 1983,
 3 and \$17,000,000 for the fiscal year ending September 30,
 4 1984".

5 (b) Section 783(c) is amended by striking out "830" and
 6 inserting in lieu thereof "822".

7 GENERAL INTERNAL MEDICINE AND GENERAL PEDIATRICS

8 SEC. 218. (a) Section 784(b) (42 U.S.C. 295g-4(b)) is
 9 amended (1) by striking out "and" after "1979," and (2) by
 10 inserting after "1980" a comma and the following:
 11 "\$30,000,000 for the fiscal year ending September 30, 1982,
 12 \$32,000,000 for the fiscal year ending September 30, 1983,
 13 and \$34,000,000 for the fiscal year ending September 30,
 14 1984".

15 (b) Section 784(a) is amended—

16 (1) by inserting ", public or private nonprofit hos-
 17 pital, or any other public or private nonprofit entity"
 18 after "osteopathy"; and

19 (2) by striking out "and" at the end of paragraph
 20 (1), by striking out the period at the end of paragraph
 21 (2) and inserting a semicolon, and by adding at the end
 22 the following:

23 "(3) to plan, develop, and operate programs for
 24 the training of physicians who plan to teach in general

1 internal medicine and general pediatrics training pro-
2 grams; and

3 “(4) to provide assistance (in the form of trainee-
4 ships and fellowships) to physicians who are partici-
5 pants in any such program.”.

6 FAMILY MEDICINE AND GENERAL PRACTICE OF
7 DENTISTRY

8 SEC. 219. (a) Section 786(d) (42 U.S.C. 295g-6(d)) is
9 amended (1) by striking out “and” after “1979,” and (2) by
10 inserting after “1980” a comma and the following:
11 “\$75,000,000 for the fiscal year ending September 30, 1982,
12 \$80,000,000 for the fiscal year ending September 30, 1983,
13 and \$85,000,000 for the fiscal year ending September 30,
14 1984”.

15 (b) Effective October 1, 1981, the Secretary of Health
16 and Human Services shall conduct a study to determine the
17 most effective and efficient means of providing financial as-
18 sistance to graduate medical education programs in the
19 United States in primary internal medicine, primary pedi-
20 atrics, and family medicine. The Secretary shall complete such
21 study and report, not later than October 1, 1982, to the
22 Committee on Interstate and Foreign Commerce of the
23 House of Representatives and the Committee on Labor and
24 Human Resources of the Senate the results of the study and
25 recommendations, if any, for legislation.

1 ASSISTANCE TO INDIVIDUALS FROM DISADVANTAGED

2 BACKGROUNDS

3 SEC. 220. Effective with respect to fiscal years begin-
4 ning after September 30, 1981, section 787 is amended to
5 read as follows:

6 "EDUCATIONAL ASSISTANCE TO INDIVIDUALS FROM
7 DISADVANTAGED BACKGROUNDS

8 "SEC. 787. (a) For the purpose of assisting individuals
9 from disadvantaged backgrounds (as determined in accord-
10 ance with criteria prescribed by the Secretary) to undertake
11 education to enter a health profession, the Secretary may
12 make grants to or enter into contracts with schools of medi-
13 cine, osteopathy, dentistry, nursing, veterinary medicine, op-
14 tometry, pharmacy, podiatry, or public health, institutions
15 providing graduate programs in health administration, or
16 other public or private nonprofit health or educational enti-
17 ties, to assist in meeting the cost of—

18 "(1) establishing secondary education programs
19 designed to increase the number of students from dis-
20 advantaged backgrounds who pursue careers in the
21 health professions;

22 "(2) strengthening the preprofessional curriculum
23 of baccalaureate degree institutions predominantly at-
24 tended by individuals from disadvantaged backgrounds;

1 “(3) establishing joint programs between bacca-
2 laureate degree institutions and health professions
3 schools or other appropriate entities designed to in-
4 crease the number of students from disadvantaged
5 backgrounds in health professions schools;

6 “(4) providing, for a period prior to the entry of
7 such individuals into the regular course of education of
8 health professions schools, preliminary education de-
9 signed to assist such individuals in successfully com-
10 pleting such regular course of education at such
11 schools, or referring such individuals to institutions
12 providing such preliminary education;

13 “(5) identifying, recruiting, and selecting individ-
14 uals from disadvantaged backgrounds for education and
15 training in a health profession;

16 “(6) facilitating the entry of such individuals into
17 such schools;

18 “(7) providing counseling, work-study opportuni-
19 ties in health service agencies, or other services de-
20 signed to assist such individuals to complete successful-
21 ly their education at such schools;

22 “(8) publicizing existing sources of financial aid
23 available to students in the education program of such
24 school or who are undertaking training necessary to
25 qualify to enroll in such program; or

1 “(9) increasing the number of faculty from disad-
2 vantaged backgrounds in the health professions
3 schools.

4 “(b)(1) There are authorized to be appropriated for
5 grants and contracts under subsection (a), \$33,000,000 for
6 the fiscal year ending September 30, 1982, \$36,000,000 for
7 the fiscal year ending September 30, 1983, and \$39,000,000
8 for the fiscal year ending September 30, 1984. Not less than
9 80 percent of the funds appropriated in any fiscal year shall
10 be obligated for grants or contracts to institutions of higher
11 education and not more than 5 percent of such funds may be
12 obligated for grants and contracts for activities described in
13 paragraph (8) of subsection (a).

14 “(2) Funds provided under grants and contracts under
15 this section may be used to provide traineeships to students
16 receiving the education described in subsection (a)(4) if such
17 students would not otherwise be able to receive such educa-
18 tion.”.

19 STARTUP, FINANCIAL DISTRESS, CONVERSION, AND

20 CURRICULUM GRANTS

21 SEC. 221. (a) Section 788(a)(1) (42 U.S.C. 295g-8) is
22 amended by striking out “medicine, osteopathy, dentistry,”.

23 (b) Effective with respect to fiscal years beginning after
24 September 30, 1981, section 788(c) is amended to read as
25 follows:

1 “(c)(1) The Secretary may make grants to schools which
2 provide the first two years of education leading to the degree
3 of doctor of medicine to assist the schools in accelerating the
4 date they will become schools of medicine.

5 “(2) The amount of a grant under paragraph (1) to a
6 school shall be equal to the product of \$25,000 and the
7 number of full-time, third-year students which the Secretary
8 estimates will enroll in the school in the school year begin-
9 ning in the fiscal year in which such grant is made. Estimates
10 by the Secretary under this paragraph of the number of full-
11 time, third-year students to be enrolled in the school may be
12 made on assurances provided by the school.

13 “(3) No grant may be made under paragraph (1) unless
14 an application for such grant is submitted to, and approved
15 by, the Secretary. Such application shall be in such form, be
16 submitted in such manner, and shall contain such informa-
17 tion, as the Secretary may by regulation prescribe. To be
18 eligible to apply for a grant under subsection (a), the appli-
19 cant must be a public or nonprofit school providing the first
20 two years of education leading to the degree of doctor of
21 medicine and be accredited by a recognized body or bodies
22 approved for such purpose by the Secretary of Education.”.

23 (c) Section 788(d) is amended—

24 (1) by striking out “and” at the end of paragraph
25 (20),

1 (2) by striking out the period at the end of para-
2 graph (21) and inserting in lieu thereof “; and”, and

3 (3) by adding at the end the following:

4 “(22) training of health professionals in the diag-
5 nosis, treatment, and prevention of diabetes and other
6 severe chronic diseases and their complications.”.

7 (d) Section 788(d)(6) is amended by inserting “dentist-
8 ry,” before “optometry”.

9 (e) Section 788(e)(1) is amended (1) by striking out
10 “and” after “1979,”, and (2) by inserting after “1980” a
11 comma and the following: “\$12,500,000 for the fiscal year
12 ending September 30, 1982, \$15,000,000 for the fiscal year
13 ending September 30, 1983, and \$17,500,000 for the fiscal
14 year ending September 30, 1984”.

15 (f)(1) Part G of title VII is amended by adding after
16 section 789 the following new section:

17 “FINANCIAL DISTRESS GRANTS

18 “SEC. 789A. (a) The Secretary may make grants to
19 schools of medicine, osteopathy, dentistry, public health, vet-
20 erinary medicine, optometry, pharmacy, and podiatry which
21 are in serious financial distress for the purposes of assisting
22 in—

23 “(1) meeting the costs of operation of any such
24 school,

1 “(2) meeting accreditation requirements if they
2 have a special need to be assisted in meeting such re-
3 quirements,

4 “(3) carrying out appropriate operational, man-
5 agerial, and financial reforms on the basis of informa-
6 tion obtained in a comprehensive cost analysis study or
7 on the basis of other relevant information,

8 “(4) meeting the costs of maintaining the quality
9 of their educational programs, and

10 “(5) meeting the costs of strengthening their aca-
11 demic resources and capabilities.

12 A grant under this subsection shall be made for such period
13 as the Secretary may specify.

14 “(b)(1) No grant may be made under subsection (a)
15 unless an application therefor is submitted to and approved
16 by the Secretary. Such an application shall be in such form,
17 submitted in such manner, and contain such information as
18 the Secretary may prescribe.

19 “(2) Any grant under subsection (a) may be made upon
20 such terms and conditions as the Secretary determines to be
21 reasonable and necessary, including requirements that the
22 school agree—

23 “(A) to disclose any financial information or data
24 deemed by the Secretary to be necessary to determine
25 the sources or causes of the school’s financial distress,

1 “(B) to conduct a comprehensive cost analysis
2 study, and

3 “(C) to carry out appropriate operational, man-
4 agerial, and financial reforms as the Secretary may re-
5 quire, except that the Secretary shall not require
6 changes in the educational component of the school’s
7 program.

8 “(3) A recipient of a grant under subsection (a) must
9 provide assurances satisfactory to the Secretary that the re-
10 cipient will expend in carrying out its function as a school of
11 medicine, osteopathy, dentistry, public health, veterinary
12 medicine, optometry, pharmacy, or podiatry, as the case may
13 be, during each fiscal year for which such grant is made an
14 amount of funds (other than funds for construction, as deter-
15 mined by the Secretary) from non-Federal sources which is
16 at least as great as the average of the amount of funds (ex-
17 cluding expenditures of a nonrecurring nature) expended an-
18 nually by the recipient to carry out such functions in the two
19 years preceding the year in which the grant is awarded.

20 “(c) The Secretary may provide to any school eligible
21 for a grant under subsection (a) technical assistance to enable
22 the school to conduct a comprehensive cost analysis study of
23 its operations, to identify operational inefficiencies, and to de-
24 velop or carry out appropriate operational, managerial, and
25 financial reforms.

1 “(d) There are authorized to be appropriated for grants
2 under subsection (a), \$20,000,000 for the fiscal year ending
3 September 30, 1982, \$20,000,000 for the fiscal year ending
4 September 30, 1983, and \$20,000,000 for the fiscal year
5 ending September 30, 1984. Funds appropriated under this
6 subsection shall remain available until expended.”.

7 (2) Section 788 is amended—

8 (A) by striking out subsection (b); and

9 (B) by amending subsection (e)(2) to read as fol-
10 lows:

11 “(2) From the sums authorized to be appropriated under
12 paragraph (1) not more than \$5,000,000 may be obligated or
13 expended for the purposes of subsection (a).”.

14 (g)(1) Subsections (f) and (g) of section 788 are repealed
15 and subsections (c), (d), and (e) are redesignated as subsec-
16 tions (b), (c), and (d), respectively.

17 (2) Subsection (d)(1) (as so redesignated) of section 788
18 is amended by striking out “(other than the provisions of sub-
19 sections (f) and (g))”.

20 (3) The heading for section 788 is amended to read as
21 follows:

1 “STARTUP, CONVERSION, AND CURRICULUM GRANTS”

2 PART E—PUBLIC HEALTH PERSONNEL

3 INSTITUTIONAL SUPPORT, TRAINEESHIPS, AND OTHER
4 PROGRAMS

5 SEC. 230. Subpart I of part G of title VII is amended
6 as follows:

7 (1) The following section is inserted at the beginning of
8 the subpart:

9 “INSTITUTIONAL SUPPORT

10 “SEC. 791. (a) GRANTS.—The Secretary shall make
11 annual grants in accordance with this section to public and
12 other nonprofit schools of public health.

13 “(b) GRANT COMPUTATION.—The amount of the
14 annual grant under subsection (a) to be made in a fiscal year
15 to a school with an approved application for such fiscal year
16 shall be an amount which bears the same ratio to the total
17 amount appropriated for such fiscal year under subsection (d)
18 as the sum of—

19 “(1) the total number of full-time students en-
20 rolled in such school in the school year beginning in
21 such fiscal year, and

22 “(2) the number of full-time equivalents of part-
23 time students in such school for such school year,
24 bears to the sum of the total number of full-time students
25 enrolled in such school year and the number of such full-time

1 equivalents for such school year in all schools of public health
2 with approved applications for such fiscal year.

3 “(c) ENROLLMENT DETERMINATIONS.—For purposes
4 of this section:

5 “(1) Section 770(c) shall apply to regulations of
6 the Secretary under this section relating to the deter-
7 mination of the number of full-time students enrolled in
8 a school eligible for a grant under subsection (a).

9 “(2) The number of full-time equivalents of part-
10 time students in a school of public health for any
11 school year is a number equal to—

12 “(A) the total number of credit hours of in-
13 struction in such year for which part-time stu-
14 dents in such school, who are pursuing a course
15 of study leading to a graduate degree in public
16 health or an equivalent degree, have enrolled, di-
17 vided by

18 “(B) the greater of (i) the number of credit
19 hours of instruction which a full-time student in
20 such school was required to take in such year, or
21 (ii) 9,

22 rounded to the next highest whole number.

23 “(3) The term ‘full-time students’ (whether such
24 term is used by itself or in connection with a particular
25 year-class) means students pursuing a full-time course

1 of study leading to a graduate degree in public health
2 or an equivalent degree.

3 “(d) AUTHORIZATIONS OF APPROPRIATIONS.—For the
4 purpose of making grants under subsection (a) there are au-
5 thorized to be appropriated \$8,000,000 for the fiscal year
6 ending September 30, 1982, \$9,000,000 for the fiscal year
7 ending September 30, 1983, and \$10,000,000 for the fiscal
8 year ending September 30, 1984.

9 “(e) GRANT REQUIREMENTS.—The Secretary shall not
10 make a grant under subsection (a) to any school in a fiscal
11 year beginning after September 30, 1981, unless—

12 “(1) the application for the grant contains, or is
13 supported by, assurances satisfactory to the Secretary
14 that the applicant will expend in carrying out its func-
15 tions as a school of public health during the fiscal year
16 for which such grant is sought, an amount of funds
17 (other than funds for construction as determined by the
18 Secretary) from non-Federal sources which is at least
19 as great as the amount of funds expended by such ap-
20 plicant for such purpose (excluding expenditures of a
21 nonrecurring nature) in the fiscal year preceding the
22 fiscal year for which such grant is sought; and

23 “(2) the school maintains an enrollment of full-
24 time first-year students, for the school year beginning
25 in the fiscal year for which a grant under subsection (a)

1 is sought, which exceeds the number of full-time first-
2 year students enrolled in such school in the school year
3 beginning in the fiscal year ending September 30,
4 1978—

5 “(A) by 5 percent of such number if such
6 number was not more than 100, or

7 “(B) by 2.5 percent of such number, or 5
8 students, whichever is greater, if such number
9 was more than 100.

10 The Secretary may waive (in whole or in part) application of
11 the requirements of paragraph (2) to a school if the Secretary
12 determines, after receiving the written recommendation of
13 the appropriate accreditation body or bodies (approved for
14 such purposes by the Secretary of Education) that compli-
15 ance by such school with such requirement will prevent it
16 from maintaining its accreditation.

17 “(f) APPLICATIONS.—

18 “(1) No grant may be made under subsection (a)
19 unless an application therefor is submitted to and ap-
20 proved by the Secretary. The Secretary may from time
21 to time set dates (not earlier than in the fiscal year
22 preceding the year for which a grant is sought) by
23 which such applications must be filed.

1 “(2) To be eligible for a grant under subsection (a)
2 the applicant must be accredited as determined in ac-
3 cordance with section 772(b).

4 “(3) The Secretary shall not approve or disap-
5 prove any application for a grant under subsection (a)
6 except after consultation with the National Advisory
7 Council on Health Professions Education (established
8 by section 702).

9 “(4) A grant under subsection (a) may be made
10 only if the application therefor—

11 “(A) is approved by the Secretary upon his
12 determination that the applicant (and its applica-
13 tion) meet the eligibility conditions prescribed by
14 subsection (e) and paragraph (2) of this subsection;

15 “(B) contains such additional information as
16 the Secretary may require to make the determina-
17 tions required of him under subsection (a); and

18 “(C) provides for such fiscal control and ac-
19 counting procedures and reports, including the use
20 of such standard procedures for the recording and
21 reporting of financial information as the Secretary
22 may prescribe, and access to the records of the
23 applicant, as the Secretary may require to enable
24 him to determine the costs to the applicant of its

1 program for the education or training of
2 students.”.

3 (2) Section 748 is transferred to the subpart, inserted
4 after the section 791 added by paragraph (1), redesignated as
5 section 792, and is amended (A) by striking out “749” in
6 subsection (a)(2) and inserting in lieu thereof “794B”, (B) by
7 striking out “postbaccalaureate” in subsection (b)(3)(A)(i) and
8 inserting in lieu thereof “baccalaureate”, (C) by striking out
9 “and” after “1979;” in subsection (c), and (D) by inserting
10 before the period in such subsection a semicolon and the fol-
11 lowing: “\$9,000,000 for the fiscal year ending September
12 30, 1982; \$10,000,000 for the fiscal year ending September
13 30, 1983; and \$11,000,000 for the fiscal year ending Sep-
14 tember 30, 1984”.

15 (3) The section 792 entitled “SPECIAL PROJECTS FOR
16 ACCREDITED SCHOOLS OF PUBLIC HEALTH AND GRADUATE
17 PROGRAMS IN HEALTH ADMINISTRATION” is inserted after
18 the section inserted by paragraph (2), redesignated as section
19 793, and is amended (A) in the section heading by striking
20 out “AND GRADUATE PROGRAMS IN HEALTH ADMINISTRA-
21 TION”, (B) by striking out subsection (b) and redesignating
22 subsection (c) as subsection (b), and (C) in subsection (b) (as
23 so redesignated) by (i) striking out “and” after “1979;”, and
24 (ii) inserting after “1980” a semicolon and the following:
25 “\$5,500,000 for the fiscal year ending September 30, 1982;

1 \$6,000,000 for the fiscal year ending September 30, 1983;
2 and \$6,500,000 for the fiscal year ending September 30,
3 1984".

4 (4) The following section is inserted after section 793
5 (as so redesignated):

6 "MIDCAREER TRAINING AND EDUCATION

7 "SEC. 794. (a) The Secretary may make grants to and
8 enter into contracts with public and nonprofit private entities
9 for the establishment, operation, and administration of cen-
10 ters to provide intensive, short-term, advanced training, to
11 individuals with demonstrated expertise in health policy and
12 management, in—

13 "(1) health systems management,

14 "(2) health policy, planning, and regulation,

15 "(3) environmental policy and management,

16 "(4) financial management and strategy in health
17 care,

18 "(5) the management of collaboration between
19 health care entities,

20 "(6) the management of small health care entities
21 in inner cities and rural areas, and

22 "(7) other matters which will increase the capa-
23 bilities of such individuals and broaden their perspec-
24 tives in carrying out their functions.

1 “(b)(1) The amount of any grant or contract under sub-
2 section (a) shall be determined by the Secretary. No grant
3 may be made or contract entered into unless an application
4 therefor is submitted to and approved by the Secretary. Such
5 an application shall be in such form, submitted in such
6 manner, and contain such information, as the Secretary shall
7 by regulation prescribe.

8 “(2) The Secretary shall, to the extent feasible, make
9 grants and enter into contracts under subsection (a) for cen-
10 ters in such a manner that there is an appropriate geographic
11 distribution of the centers.

12 “(c) For the purpose of grants and contracts under sub-
13 section (a) there are authorized to be appropriated
14 \$2,500,000 for the fiscal year ending September 30, 1982,
15 \$3,000,000 for the fiscal year ending September 30, 1983,
16 and \$3,500,000 for the fiscal year ending September 30,
17 1984.”.

18 (5) The section 791 entitled “GRANTS FOR GRADUATE
19 PROGRAMS IN HEALTH ADMINISTRATION” is inserted after
20 the section added by paragraph (4), redesignated as section
21 794A, and is amended as follows:

22 (A) Subsection (c)(2)(A)(i)(II) is amended by strik-
23 ing out “\$100,000” and inserting in lieu thereof
24 “\$150,000”.

25 (B) Subsection (c)(2)(A)(ii) is amended—

1 (i) by striking out "1978" and inserting in
2 lieu thereof "1981"; and

3 (ii) by striking out "1976" and inserting in
4 lieu thereof "1980".

5 (C) Subsection (c)(2)(A) is amended—

6 (i) by striking out "and" at the end of clause
7 (ii)(II); and

8 (ii) by redesignating clause (iii) as clause (iv)
9 and by inserting the following new clause after
10 clause (ii):

11 "(iii) contains assurances satisfactory to the Sec-
12 retary that the program for which such application was
13 submitted shall provide a concentration or special em-
14 phasis on one or more of the following:

15 "(I) health planning,

16 "(II) health policy,

17 "(III) ambulatory care services,

18 "(IV) long-term care,

19 "(V) home health care,

20 "(VI) multi-unit care systems,

21 "(VII) comprehensive prepaid service sys-
22 tems,

23 "(VIII) mental health administration, and

1 “(IX) any other health care delivery system
2 determined by the Secretary to require special
3 emphasis; and”.

4 (D) Subsection (c)(3) is amended by striking out
5 “Commissioner” and inserting in lieu thereof “Secre-
6 tary”.

7 (E) Subsection (d) is amended—

8 (i) by striking out “and” after “1979,”; and

9 (ii) by inserting after “1980” a comma and
10 the following: “\$4,500,000 for the fiscal year
11 ending September 30, 1982, \$5,000,000 for the
12 fiscal year ending September 30, 1983, and
13 \$5,500,000 for the fiscal year ending September
14 30, 1984”.

15 (6) Section 749 is inserted after the section inserted by
16 paragraph (5), redesignated as section 794B, and is amended
17 (A) by striking out “postbaccalaureate” in subsection
18 (b)(3)(A) and inserting in lieu thereof “baccalaureate”, (B) by
19 striking out “and” after “1979,” in subsection (c), and (C) by
20 inserting before the period in such subsection a semicolon and
21 the following: “\$3,000,000 for the fiscal year ending Sep-
22 tember 30, 1982; \$3,500,000 for the fiscal year ending Sep-
23 tember 30, 1983; and \$4,000,000 for the fiscal year ending
24 September 30, 1984”.

1 (7) The following sections are inserted after section
2 749B (as so redesignated):

3 “GRANTS TO DEPARTMENTS OF PREVENTIVE OR
4 COMMUNITY MEDICINE OR DENTISTRY

5 “SEC. 794C. (a) The Secretary may make grants to
6 schools of medicine, dentistry, and osteopathy for the costs of
7 projects—

8 “(1) to establish, maintain, and improve academic
9 administrative units in preventive or community medi-
10 cine or dentistry;

11 “(2) to improve predoctoral and postdoctoral in-
12 struction in preventive, community, or occupational
13 medicine or dentistry;

14 “(3) to plan, develop, and operate joint programs
15 between academic administrative units in preventive or
16 community medicine or dentistry and such units in
17 other clinical specialties, which programs integrate the
18 teaching of clinical preventive, community, or occupa-
19 tional medicine or dentistry within clinical programs
20 for other medical or dental disciplines; and

21 “(4) to plan, develop, and operate special pro-
22 grams to train teachers and researchers in the fields of
23 preventive, community, or occupational medicine or
24 dentistry.

1 “(b)(1) The amount of any grant under subsection (a)
2 shall be determined by the Secretary. No grant may be made
3 under subsection (a) unless an application therefor is submit-
4 ted to and approved by the Secretary. Such an application
5 shall be in such form, submitted in such manner, and contain
6 such information, as the Secretary shall by regulation
7 prescribe.

8 “(2) To be eligible for a grant under subsection (a), an
9 applicant school must have, or demonstrate an intention to
10 establish, an academic administrative unit in preventive or
11 community medicine or dentistry or an academic or adminis-
12 trative unit which has the primary responsibility, within that
13 medical, dental, or osteopathic school, for teaching the princi-
14 ples of preventive or community medicine or dentistry.

15 “(c) For the purpose of grants under subsection (a),
16 there are authorized to be appropriated \$3,000,000 for the
17 fiscal year ending September 30, 1982, and \$4,000,000 for
18 the fiscal year ending September 30, 1983, and \$5,000,000
19 for the fiscal year ending September 30, 1984.

20 “TRAINING IN PREVENTIVE MEDICINE

21 “SEC. 794D. (a) The Secretary may make grants to
22 schools of medicine and schools of public health to meet the
23 costs of projects—

1 “(1) to plan and develop new residency training
2 programs and to develop and expand accredited resi-
3 dency training programs in preventive medicine; and

4 “(2) to provide financial assistance to residency
5 trainees enrolled in such programs.

6 “(b)(1) The amount of any grant under subsection (a)
7 shall be determined by the Secretary. No grant may be made
8 under subsection (a) unless an application therefor is submit-
9 ted to and approved by the Secretary. Such an application
10 shall be in such form, submitted in such manner, and contain
11 such information, as the Secretary shall by regulation
12 prescribe.

13 “(2) To be eligible for a grant under subsection (a), the
14 applicant must demonstrate to the Secretary that it has or
15 will have available full-time faculty members with training
16 and experience in the fields of preventive medicine and sup-
17 port from other faculty members trained in public health and
18 other relevant specialties and disciplines.

19 “(c) For the purpose of grants under subsection (a),
20 there are authorized to be appropriated \$7,000,000 for the
21 fiscal year ending September 30, 1982, and \$8,000,000 for
22 the fiscal year ending September 30, 1983, and \$9,000,000
23 for the fiscal year ending September 30, 1984.

- 1 "SPECIAL CURRICULA DEVELOPMENT PROJECTS FOR
2 GRADUATE PROGRAMS IN HEALTH ADMINISTRATION
- 3 "SEC. 794E. (a) The Secretary may make grants to
4 assist education institutions with accredited programs in
5 health administration to meet the costs of developing cur-
6 ricula designed to improve training in health care manage-
7 ment. Such curricula may include—
- 8 "(1) finance (particularly as applied to health
9 care);
- 10 "(2) marketing (particularly as applied to health
11 care);
- 12 "(3) economics (including macroeconomics and mi-
13 croeconomics) and shall emphasize health economics;
- 14 "(4) epidemiology and health planning;
- 15 "(5) health policy, law, and regulation;
- 16 "(6) quality assurance and assessment;
- 17 "(7) information systems;
- 18 "(8) health services organization and management
19 for students in health disciplines other than health ad-
20 ministration; and
- 21 "(9) management of ambulatory care services.
- 22 "(b) For purposes of subsection (a) and section 794F,
23 the term 'accredited program in health administration' means
24 a graduate program which is accredited for the purpose of
25 training individuals in health administration by a body or

1 bodies approved for such purpose by the Secretary of Educa-
 2 tion and which meets such other standards as the Secretary
 3 of Education may by regulation prescribe.

4 “(c) For the purpose of grants under subsection (a),
 5 there are authorized to be appropriated \$4,000,000 for the
 6 fiscal year ending September 30, 1982, \$5,000,000 for the
 7 fiscal year ending September 30, 1983, and \$9,000,000 for
 8 the fiscal year ending September 30, 1984.

9 “FACULTY DEVELOPMENT PROGRAMS

10 “SEC. 794F. (a) The Secretary may make grants to
 11 assist accredited schools of public health and other education
 12 institutions with accredited programs in health administration
 13 to meet the costs of establishing and operating faculty devel-
 14 opment programs. Such faculty development program shall—

15 “(1) train individuals in management or other dis-
 16 ciplines that are, in the judgment of the Secretary, un-
 17 derrepresented in programs of health administration
 18 and necessary to improve training in health care man-
 19 agement; and

20 “(2) train individuals experienced in such disci-
 21 plines with respect to health care issues relating to the
 22 teaching of health administration.

23 “(b) No grant may be made under subsection (a) unless
 24 an application therefor is submitted to and approved by the
 25 Secretary. Such an application shall be in such form, be sub-

1 mitted in such manner, and contain such information as the
2 Secretary shall prescribe. The Secretary may not approve an
3 application for a grant under subsection (a) unless such appli-
4 cation contains assurances satisfactory to the Secretary that
5 at least three individuals shall complete the program in each
6 year for which an application is made.

7 “(c) Grant funds awarded under subsection (a) shall be
8 used to provide twelve-month fellowships to individuals
9 who—

10 “(1) have received a doctoral degree or equivalent
11 professional recognition in a discipline determined by
12 the Secretary to be underrepresented in programs of
13 health administration and necessary to improve train-
14 ing in health care management; and

15 “(2) agree to serve as a faculty member for a
16 period of not less than two years in an accredited
17 school of public health or other educational program
18 with accredited programs in health administration.

19 “(d) For the purpose of grants under subsection (a),
20 there are authorized to be appropriated \$1,000,000 for the
21 fiscal year ending September 30, 1982, \$1,000,000 for the
22 fiscal year ending September 30, 1983, and \$1,000,000 for
23 the fiscal year ending September 30, 1984.”.

1 (8) The section 793 entitled "Statistics and Annual
2 Report" is inserted after section 794F and redesignated as
3 section 794G.

4 STUDY

5 SEC. 231. (a) The Secretary of Health and Human
6 Services shall, in consultation with the Administrator of the
7 Environmental Protection Agency and the Secretary of
8 Labor and on an ongoing basis, assess and identify—

9 (1) current and projected personnel needs for the
10 implementation of Federal, State, and local environ-
11 mental protection and occupational health laws, and

12 (2) current and projected personnel needs of envi-
13 ronmental and occupational health.

14 (b) The Secretary of Health and Human Services
15 shall—

16 (1) study and assess the policies, programs, and
17 activities of the Department of Health and Human
18 Services, the Department of Labor, the Environmental
19 Protection Agency, and other Federal departments and
20 agencies for the education (including continuing educa-
21 tion) and training of the personnel of such departments
22 and agencies in environmental and occupational health
23 and in the implementation of environmental protection
24 and occupational health laws and the training programs
25 of such departments and agencies (and their policies re-

1 pecting such programs) under which persons engaged
2 in the implementation of such laws would be able to
3 receive training in environmental and occupational
4 health and persons engaged in research or providing
5 training in environmental and occupational health
6 would be able to receive training in the implementation
7 of environmental protection and occupational health
8 laws;

9 (2) study and assess methods by which the Secre-
10 tary and the Administrator of the Environmental Pro-
11 tection Agency may provide technical assistance to
12 other Federal departments and agencies and to States
13 and political subdivisions of States to assist them in the
14 development of programs to identify their respective
15 needs for personnel to implement their environmental
16 protection and occupational health laws, methods of as-
17 sisting States to plan to meet such needs, and methods
18 of assisting States in meeting such needs;

19 (3) study and assess the efficacy of the establish-
20 ment, jointly by the Federal Government and the
21 States, of a register (A) of personnel with training or
22 substantial experience in environmental health and in
23 the implementation of environmental protection laws
24 and of the types of positions available to such person-
25 nel, and (B) of personnel with training or substantial

1 experience in occupational health and in the implemen-
2 tation of occupational health laws and of the types of
3 positions available to such personnel;

4 (4) study and assess programs to encourage inno-
5 vation in the curricula for education and training in
6 educational institutions, including schools of medicine,
7 osteopathy, and public health, in environmental and oc-
8 cupational health and in education and training in the
9 implementation of environmental protection and occu-
10 pational health laws;

11 (5) study and assess programs to encourage and
12 enable individuals with training in environmental or oc-
13 cupational health or in the implementation of environ-
14 mental protection or occupational health laws to under-
15 take such additional education or training, such as spe-
16 cialized postgraduate education, as may be necessary
17 to enable them to fill personnel needs in positions in
18 environmental or occupational health or in the imple-
19 mentation of environmental protection or occupational
20 health laws;

21 (6) identify geographical areas where training in
22 environmental and occupational health or in the imple-
23 mentation of environmental protection and occupational
24 health laws is insufficient and determine the most ef-

1 fective means of providing such training to individuals
2 in such areas;

3 (7) determine the most effective and expeditious
4 means of encouraging individuals to undertake educa-
5 tion and training in environmental and occupational
6 health and in the implementation of environmental pro-
7 tection and occupational health laws and encouraging
8 individuals with such training and education to obtain
9 positions in environmental or occupational health or in
10 the implementation of such laws and to remain in such
11 positions;

12 (8) determine if a requirement of service in an un-
13 derserved area as a condition to the receipt of Federal
14 financial assistance (A) affects the number of individ-
15 uals applying for such assistance, (B) encourages indi-
16 viduals to undertake education and training in environ-
17 mental and occupational health and in the implementa-
18 tion of environmental protection and occupational
19 health laws, (C) encourages individuals to remain in an
20 underserved area, and (D) will be met by individuals
21 receiving such assistance; and

22 (9) determine the extent of the cooperation and
23 coordination between the Department of Health and
24 Human Services, the Environmental Protection
25 Agency, and the Occupational Safety and Health Ad-

1 ministration in the performance of their respective
2 functions relating to the education and training of per-
3 sonnel for the administration and enforcement of envi-
4 ronmental protection and occupational health laws or
5 for other positions in environmental and occupational
6 health and identify areas where such functions and
7 agencies are duplicative or conflicting.

8 (c) The Secretary shall report annually to the Congress
9 respecting the activities undertaken pursuant to subsection
10 (a). Within two years after the date of enactment of the first
11 appropriation for the Secretary, the Secretary shall report to
12 the Congress respecting the Secretary's activities under sub-
13 section (b). Each report under this subsection shall contain
14 such recommendations as the Secretary determines appropri-
15 ate for administrative actions and legislation to carry out the
16 recommendations of the Secretary. The Department of
17 Labor, the Environmental Protection Agency, and the Occu-
18 pational Safety and Health Administration shall be provided
19 copies of reports made by the Secretary under this
20 subsection.

21 (d) There are authorized to be appropriated to carry out
22 this section \$1,000,000 for the fiscal year ending September
23 30, 1982, \$1,000,000 for the fiscal year ending September
24 30, 1983, and \$1,000,000 for the fiscal year ending Septem-
25 ber 30, 1984.

1 PART F—ALLIED HEALTH PERSONNEL

2 PROJECT GRANTS

3 SEC. 235. Section 796(d)(1) (42 U.S.C. 295h-5) is
 4 amended (1) by striking out “and” after “1979;”, and (2) by
 5 inserting after “1980” a semicolon and the following:
 6 “\$9,500,000 for the fiscal year ending September 30, 1982;
 7 \$10,000,000 for the fiscal year ending September 30, 1983;
 8 and \$10,000,000 for the fiscal year ending September 30,
 9 1984”.

10 TRAINEESHIPS

11 SEC. 236. Section 797(c) (42 U.S.C. 295h-6) is amend-
 12 ed (1) by striking out “and” after “1979;”, and (2) by insert-
 13 ing after “1980” a semicolon and the following: “\$1,400,000
 14 for the fiscal year ending September 30, 1982; \$1,500,000
 15 for the fiscal year ending September 30, 1983; and
 16 \$1,600,000 for the fiscal year ending September 30, 1984”.

17 ASSISTANCE TO DISADVANTAGED INDIVIDUALS

18 SEC. 237. Section 798(c) (42 U.S.C. 295h-7) is amend-
 19 ed (1) by striking out “and” after “1979;”, and (2) by insert-
 20 ing after “1980” a comma and the following: “\$1,000,000
 21 for the fiscal year ending September 30, 1982, \$1,000,000
 22 for the fiscal year ending September 30, 1983, and
 23 \$1,000,000 for the fiscal year ending September 30, 1984”.

1

DEFINITION

2

SEC. 238. Section 795(2)(A) (42 U.S.C. 295h-4(2)(A))

3

is amended (1) by striking out “medical technology, optomet-

4

ric technology, dental hygiene, or in any of such other of”

5

and inserting in lieu thereof “such of”, and (2) in clause (ii)

6

by striking out “optometric technology, dental hygiene, or

7

such other curricula” and inserting in lieu thereof “such

8

curricula”.

9

TITLE III—NURSE TRAINING

10

CONSTRUCTION

11

SEC. 301. (a)(1) Section 801 (42 U.S.C. 296) is

12

amended (A) by inserting “in health manpower shortage

13

areas designated under section 332” after “nursing”, (B) by

14

striking out “and” after “1978,”, and (C) by inserting after

15

“1980” a comma and the following: “\$1,000,000 for the

16

fiscal year ending September 30, 1982, \$1,000,000 for the

17

fiscal year ending September 30, 1983, and \$1,000,000 for

18

the fiscal year ending September 30, 1984”.

19

(2) Section 802(b)(1) (42 U.S.C. 296a(b)(1)) is amended

20

by inserting “in a health manpower shortage area designated

21

under section 332” before the semicolon.

22

(b) Section 805(a) (42 U.S.C. 296d(a)) is amended by

23

striking out “1980” and inserting in lieu thereof “1984”.

INSTITUTIONAL SUPPORT

2 SEC. 302. (a) Effective with respect to appropriations
3 under section 810(f) of the Public Health Service Act for
4 fiscal years beginning after September 30, 1981, section
5 810(a) (42 U.S.C. 296e(a)) is amended by striking out para-
6 graphs (1), (2), and (3) and inserting in lieu thereof
7 the following:

8 “(1)(A) For the fiscal year ending September 30,
9 1982, each collegiate school of nursing shall receive an
10 amount equal to the product of—

11 “(i) \$200, and

12 “(ii) the sum of (I) the number of full-time
13 students enrolled in each of the last two years of
14 such school in the fiscal year for which the grant
15 is to be made, and (II) the number of full-time
16 equivalents of part-time students for such school
17 for such fiscal year.

18 “(B) For the fiscal year ending September 30,
19 1983, each collegiate school of nursing shall receive an
20 amount equal to the product of \$210 and the sum de-
21 scribed in subparagraph (A)(ii).

“(C) For the fiscal year ending September 30, 1984, each collegiate school of nursing shall receive an amount equal to the product of \$220 and the sum described in subparagraph (A)(ii).

1 “(2)(A) For the fiscal year ending September 30,
2 1982, each associate degree school of nursing and each
3 diploma school of nursing shall receive an amount
4 equal to the product of—

5 “(i) \$200, and

6 “(ii) the sum of (I) the number of full-time
7 students enrolled in such school in the fiscal year
8 for which the grant is to be made, and (II) the
9 number of full-time equivalents of part-time stu-
10 dents for such school for such fiscal year.

11 “(B) For the fiscal year ending September 30,
12 1983, each such school of nursing shall receive an
13 amount equal to the product of \$210 and the sum de-
14 scribed in subparagraph (A)(ii).

15 “(C) For the fiscal year ending September 30,
16 1984, each such school of nursing shall receive an
17 amount equal to the product of \$220 and the sum de-
18 scribed in subparagraph (A)(ii).”

19 (b) Section 810(c)(2) is amended—

20 (1) in subparagraph (A), by striking out “June 30,
21 1975” and all that follows in that subparagraph and
22 inserting in lieu thereof “September 30, 1979, by 15
23 percent or 10 students, whichever is greater.”;

24 (2) by amending subparagraph (B) to read as
25 follows:

1 “(B) In the case of a collegiate school of nursing,
2 the school has provided reasonable assurances to the
3 Secretary that it will carry out, in accordance with a
4 plan submitted by the school to the Secretary and ap-
5 proved by the Secretary, in the school year beginning
6 in the fiscal year in which such grant is to be made
7 and in each school year thereafter beginning in a fiscal
8 year in which such a grant is made, a program for the
9 training of nurse practitioners (as defined in section
10 822).”; and

11 (3) by adding after subparagraph (B) the
12 following:

13 “(C) The application of the school for such grant
14 contains or is supported by reasonable assurances sat-
15 isfactory to the Secretary that (i) it will carry out, in
16 accordance with a plan submitted by the school to the
17 Secretary and approved by the Secretary, in the school
18 year beginning in the fiscal year in which such grant is
19 to be made and in each school year thereafter begin-
20 ning in a fiscal year in which such a grant is made, a
21 program to identify, recruit, enroll, retain, and gradu-
22 ate individuals from disadvantaged backgrounds (as de-
23 termined in accordance with criteria prescribed by the
24 Secretary), and (ii) under such program at least 20
25 percent of each year’s entering full-time students (or

1 10 students, whichever is greater) will be comprised of
2 such individuals.

3 “(D) In the case of a collegiate school of nursing,
4 the application of the school for such grant contains or
5 is supported by reasonable assurances satisfactory to
6 the Secretary that in the school year beginning in the
7 fiscal year in which such grant is to be made and in
8 each school year thereafter beginning in a fiscal year in
9 which such a grant is made at least 20 percent of each
10 year’s entering full-time students (or 10 students,
11 whichever is greater) shall be comprised of individuals
12 who have a degree from an associate degree school of
13 nursing or a diploma or equivalent indicia from a di-
14 ploma school of nursing.

15 “(E) In the case of an associate degree school of
16 nursing or a diploma school of nursing, the application
17 of the school for such grant contains or is supported by
18 reasonable assurances satisfactory to the Secretary
19 that in the school year beginning in the fiscal year in
20 which such grant is to be made and in each school
21 year thereafter beginning in a fiscal year in which such
22 a grant is made at least 20 percent of each year’s en-
23 tering full-time students (or 10 students, whichever is
24 greater) shall be comprised of individuals who are
25 licensed practical or vocational nurses.

1 “(F) The application of the school for such grant
2 contains or is supported by reasonable assurances sat-
3 isfactory to the Secretary that in the school year be-
4 ginning in the fiscal year in which such grant is to be
5 made and in each school year thereafter beginning in a
6 fiscal year in which such a grant is made the number
7 of part-time students enrolled in the school in its pro-
8 gram leading to the degree or diploma or equivalent in-
9 dicia which it awards will be at least 20 percent of all
10 the students enrolled in the school in such program.”.

11 (c) Section 810(d) is amended (1) by striking out “part
12 D” each place it occurs and inserting in lieu thereof “part
13 B”, and (2) by adding after paragraph (2) the following:

14 “(3) The number of full-time equivalents of part-
15 time students for a school of nursing for any school
16 year is a number equal to—

17 “(A) the total number of credit hours of in-
18 struction in such year for which part-time stu-
19 dents of such school, who are pursuing a course
20 of study leading to a degree or diploma or equiva-
21 lent indicia, have enrolled, divided by

22 “(B) the number of credit hours of instruc-
23 tion which a full-time student of such school was
24 required to take in such year,

1 rounded to the next highest whole number, except that
2 in the case of a collegiate school of nursing, only the
3 credit hours of instruction in courses offered to stu-
4 dents who are enrolled in the third or fourth year pro-
5 gram of instruction of such school shall be considered
6 in making the computation under subparagraph (A).”.

7 (d) Section 810(f) is amended (1) by striking out “and”
8 after “1978,”, and (2) by inserting after “1980” a comma
9 and the following: “\$27,500,000 for the fiscal year ending
10 September 30, 1982, \$30,000,000 for the fiscal year ending
11 September 30, 1983, and \$32,500,000 for the fiscal year
12 ending September 30, 1984”.

13 (e) The heading for section 810 is amended to read as
14 follows:

15 “INSTITUTIONAL SUPPORT”

16 SPECIAL PROJECTS

17 SEC. 303. (a)(1) Section 820(a) (42 U.S.C. 296k(a)) is
18 amended (A) by striking out paragraphs (1), (2), and (8), (B)
19 by inserting “or” at the end of paragraph (6), (C) in para-
20 graph (7) by striking out “, nursing assistants, and other
21 paraprofessional nursing personnel; or” and inserting in lieu
22 thereof a period, and (D) by redesignating paragraphs (3), (4),
23 (5), (6), and (7) as paragraphs (1), (2), (3), (4), and (5),
24 respectively.

1 (2) Notwithstanding the amendment made by paragraph
2 (1), an entity which received a grant or contract under sec-
3 tion 820(a) of the Public Health Service Act for the fiscal
4 year ending September 30, 1981, for a project described in
5 paragraph (1), (2), or (8) of such section (as in effect when it
6 received the grant or contract) may receive one additional
7 grant or contract under such section for such project.

8 (b) Section 820(d) is amended—

9 (1) by striking out “and” after “1978,” and by
10 inserting after “1980” a comma and the following:
11 “\$17,500,000 for the fiscal year ending September 30,
12 1982, \$20,000,000 for the fiscal year ending Septem-
13 ber 30, 1983, and \$22,500,000 for the fiscal year
14 ending September 30, 1984”; and

15 (2) by amending the last sentence to read as fol-
16 lows: “Of the funds appropriated under this subsection
17 for any fiscal year beginning after September 30,
18 1981, not less than 20 percent of the funds shall be
19 obligated for payments under grants and contracts for
20 special projects described in subsection (a)(1) and not
21 less than 20 percent of the funds shall be obligated for
22 payments under grants and contracts for special proj-
23 ects described in subsection (a)(4).”.

1 ADVANCED NURSE TRAINING

2 SEC. 304. (a) Section 821(a)(1) (42 U.S.C. 296l(a)(1)) is
3 amended by striking out "to each" and inserting in lieu
4 thereof "to teach".

5 (b) Section 821(b) is amended (1) by striking out "and"
6 after "1978,", and (2) by inserting after "1980" a comma
7 and the following: "\$13,500,000 for the fiscal year ending
8 September 30, 1982, \$15,000,000 for the fiscal year ending
9 September 30, 1983, and \$16,500,000 for the fiscal year
10 ending September 30, 1984".

11 NURSE PRACTITIONER PROGRAMS

12 SEC. 305. (a) Section 822(b)(1) (42 U.S.C. 296m(b)(1))
13 is amended by striking out "who are residents of a health
14 manpower shortage area (designated under section 332)" and
15 inserting in lieu thereof a period and the following: "In con-
16 sidering applications for a grant or contract under this sub-
17 section, the Secretary shall give special consideration to ap-
18 plications for traineeships to train individuals who are resi-
19 dents of health manpower shortage areas designated under
20 section 332."

21 (b)(1) Section 822(b)(3) is amended by inserting before
22 the period the following: "for a period equal to one month for
23 each month for which the recipient receives such a trainee-
24 ship".

1 (2) Section 822(b) is amended by adding after paragraph
2 (3) the following:

3 “(4)(A) If, for any reason, an individual who received a
4 traineeship under paragraph (1) fails to complete a service
5 obligation under paragraph (3), such individual shall be liable
6 for the payment of an amount equal to the cost of tuition and
7 other education expenses and other payments paid under the
8 traineeship, plus interest at the maximum legal prevailing
9 rate.

10 “(B) When an individual who received a traineeship is
11 academically dismissed or voluntarily terminates academic
12 training, such individual shall be liable for repayment to the
13 Government for an amount equal to the cost of tuition and
14 other educational expenses paid to or for such individual from
15 Federal funds plus any other payments which were received
16 under the traineeship.

17 “(C) Any amount which the United States is entitled to
18 recover under subparagraph (A) or (B) shall, within the
19 three-year period beginning on the date the United States
20 becomes entitled to recover such amount, be paid to the
21 United States.

22 “(D) The Secretary shall by regulation provide for the
23 waiver or suspension of any obligation under subparagraph
24 (A) or (B) applicable to any individual whenever compliance
25 by such individual is impossible or would involve extreme

1 hardship to such individual and if enforcement of such obliga-
 2 tion with respect to any individual would be against equity
 3 and good conscience.”.

4 (3) The amendments made by paragraphs (1) and (2)
 5 shall apply with respect to traineeships which are awarded
 6 under section 822(b) of the Public Health Service Act after
 7 the date of the enactment of this Act.

8 (c) Section 822(e) is amended (1) by striking out “and”
 9 after “1978,”, and (2) by inserting after “1980” a comma
 10 and the following: “\$18,500,000 for the fiscal year ending
 11 September 30, 1982, \$20,000,000 for the fiscal year ending
 12 September 30, 1983, and \$21,500,000 for the fiscal year
 13 ending September 30, 1984”.

14 TRAINEESHIPS

15 SEC. 306. (a)(1) Subparagraph (C) of section 830(a)(1)
 16 (42 U.S.C. 297(a)(1)) is amended to read as follows:

17 “(C) to serve as nurse midwives, or”.

18 (2) An individual who received a traineeship under sec-
 19 tion 830(a) of the Public Health Service Act for the fiscal
 20 year ending September 30, 1981, to receive training to serve
 21 as a nurse practitioner may, notwithstanding the amendment
 22 made by paragraph (1), receive additional traineeships
 23 under that section to complete the training to be a nurse
 24 practitioner.

25 (b) Section 830(b) is amended—

1 (1) by striking out "and" after "1978," and by
2 inserting after "1980" a comma and the following:
3 "\$17,500,000 for the fiscal year ending September 30,
4 1982, \$20,000,000 for the fiscal year ending Septem-
5 ber 30, 1983, and \$22,500,000 for the fiscal year
6 ending September 30, 1984"; and

7 (2) by adding at the end the following: "Not less
8 than 50 percent of the funds appropriated under this
9 subsection for any fiscal year shall be obligated for
10 traineeships described in subsection (a)(1)(A), except
11 that if the obligation of that amount of the funds ap-
12 propriated under this subsection will prevent the Secre-
13 tary from continuing a traineeship to an individual who
14 received a traineeship under subsection (a) for the fiscal
15 year ending September 30, 1981, the Secretary shall
16 reduce the amount to be obligated for traineeships de-
17 scribed in subsection (a)(1)(A) by such amount as may
18 be necessary for the continuation of traineeships first
19 awarded in such fiscal year."

20 NURSE ANESTHETISTS

21 SEC. 307. Section 831(b) (42 U.S.C. 297-1(b)) is
22 amended by inserting after "1980" a comma and the follow-
23 ing: "\$3,000,000 for the fiscal year ending September 30,
24 1982, \$4,000,000 for the fiscal year ending September 30,

1 1983, and \$5,000,000 for the fiscal year ending September
2 30, 1984”.

3 STUDENT LOANS

4 SEC. 308. (a) Section 835(b)(4) (42 U.S.C. 297a(b)(4)) is
5 amended by striking out “1980” and inserting in lieu thereof
6 “1984”.

7 (b)(1) Section 836(b)(1)(A) is amended by inserting after
8 “(A)” the following: “is in exceptionally needy circumstances
9 or is from a low-income or disadvantaged family (as those
10 terms are defined by regulations under subsection (j)) and”.

11 (2) The amendment made by paragraph (1) shall not
12 apply with respect to any loan under subpart II of part B of
13 title VIII of the Public Health Service Act to students who
14 received such a loan before the date of the enactment of this
15 Act.

16 (3) Section 836(b)(5) is amended by striking out “3” and
17 inserting in lieu thereof “6”.

18 (c) Section 837 (42 U.S.C. 297c) is amended (1) by
19 striking out “and” after “1978,” (2) by inserting after “Sep-
20 tember 30, 1980” a comma and the following: “\$17,500,000
21 for the fiscal year ending September 30, 1982, \$20,000,000
22 for the fiscal year ending September 30, 1983, and
23 \$22,500,000 for the fiscal year ending September 30, 1984”,
24 (3) by striking out “1981” in the second sentence and insert-

1 ing in lieu thereof "1985", and (4) by striking out "October
2 1, 1980" and inserting in lieu thereof "October 1, 1984".

3 (d) Section 839 (42 U.S.C. 297e) is amended by striking
4 out "1983" each place it occurs and inserting in lieu thereof
5 "1987".

6 SCHOLARSHIPS

7 SEC. 309. Section 845 (42 U.S.C. 297j) is amended (1)
8 by striking out "next four fiscal years" in subsections (b) and
9 (c)(1)(A) and inserting in lieu thereof "next eight fiscal
10 years", (2) by striking out "1981" in subsections (b) and
11 (c)(1)(B) and inserting in lieu thereof "1985", and (3) by
12 striking out "1980" in subsections (b) and (c)(1)(B) and in-
13 serting in lieu thereof "1984".

14 TECHNICAL

15 SEC. 310. Section 851(a) (42 U.S.C. 298(a)) is amended
16 by striking out "and the Commissioner of Education, both of
17 whom shall be ex officio members" and inserting in lieu
18 thereof "and an ex officio member".

19 TITLE IV—GRADUATE MEDICAL EDUCATION

20 NATIONAL ADVISORY COMMITTEE

21 GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY

22 COMMITTEE

23 SEC. 401. (a) Effective October 1, 1981, part A of title
24 VII is amended by inserting after section 711 the following:

1 "GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY
2 COMMITTEE

3 "SEC. 712. (a)(1) There is established the Graduate
4 Medical Education National Advisory Committee (hereinafter
5 in this section referred to as the 'Advisory Committee'). The
6 Advisory Committee shall consist of twenty-three members
7 as follows:

8 "(A) A representative of the Public Health Serv-
9 ice and a representative of the Health Care Financing
10 Administration each designated by the Secretary, a
11 representative of the Department of Defense designat-
12 ed by the Secretary of Defense, a representative of the
13 Veterans' Administration designated by the Adminis-
14 trator of Veterans' Affairs, and the Chairman of the
15 Coordinating Council on Medical Education shall each
16 be ex officio members of the Advisory Committee.

17 "(B) The Secretary shall appoint eighteen mem-
18 bers from individuals who are representative of provid-
19 ers of health care, insurers and other payers of health
20 care, and interested national and local organizations.

21 "(2)(A) Except as provided in subparagraph (B), the
22 term of office of a member of the Advisory Committee shall
23 be three years.

24 "(B) Of the members first appointed to the Advisory
25 Committee after the date of the enactment of this section—

1 “(i) six members shall be appointed to serve for
2 terms of one year, and

3 “(ii) six members shall be appointed to serve for
4 terms of two years,

5 as designated by the Secretary at the time of appointment.

6 Any member appointed to fill a vacancy occurring before the
7 expiration of the term for which the member's predecessor
8 was appointed shall be appointed only for the remainder of
9 such term. A member may serve after the expiration of the
10 member's term until a successor has taken office.

11 “(3) Members of the Advisory Committee who are offi-
12 cers or employees of the United States shall serve without
13 pay. The other members of the Advisory Committee shall be
14 entitled to receive the daily equivalent of the annual rate of
15 basic pay in effect for grade GS-18 of the General Schedule
16 for each day (including traveltime) during which they are en-
17 gaged in the actual performance of the duties vested in the
18 Committee.

19 “(4) The chairman of the Advisory Committee shall be
20 designated by the Secretary from the appointed members of
21 the Advisory Committee.

22 “(5) The Advisory Committee shall meet at the call of
23 the chairman, except that the Advisory Committee shall
24 meet at least once every calendar quarter. Notice of meetings

1 of the Advisory Committee shall be made available to the
2 public and such meetings shall be open to the public.

3 “(6)(A) The Secretary shall provide the Advisory Com-
4 mittee such support staff and administrative services as may
5 be necessary for the Advisory Committee to carry out its
6 functions under subsection (b).

7 “(B) The Secretary may enter into contracts with public
8 and other nonprofit entities, including the Coordinating
9 Council on Medical Education and its constituent members,
10 to provide assistance to the Advisory Committee in carrying
11 out its functions under subsection (b).

12 “(b) The Advisory Committee shall—

13 “(1) advise, consult with, and make recommenda-
14 tions to, the Secretary with respect to—

15 “(A) the need for and supply of physicians in
16 the various medical specialties (including subspe-
17 cialties) and with respect to the geographic distri-
18 bution of physicians;

19 “(B) the factors which affect a physician’s
20 choice of graduate medical training and the loca-
21 tion of the physician’s practice;

22 “(C) the effect that—

23 “(i) the rate of reimbursement for health
24 care services provided by physicians in the
25 different medical specialties, and

- 1 “(ii) the availability of financial support
2 for persons undergoing graduate medical
3 education,
4 has on the selection of a medical specialty or sub-
5 specialty;
6 “(D) the proportion of health services pro-
7 vided by persons undergoing graduate medical
8 education; and
9 “(E) such other matters relating to graduate
10 medical education as the Secretary may specify.
11 “(2) recommend to the Secretary goals for (A) the
12 distribution of physicians by medical specialties and
13 subspecialties, and (B) the number of graduate medical
14 education positions that should be available in each of
15 the medical specialties and subspecialties; and
16 “(3) recommend to the Secretary policies and pro-
17 cedures to achieve such goals.
18 The Advisory Committee shall inform the Secretary of the
19 data it will need to carry out its functions under this subsec-
20 tion.
21 “(c) The Advisory Committee shall consult with appro-
22 priate entities, including the Coordinating Council on Medical
23 Education and its constituent members, concerning appropri-
24 ate actions to attain the goals recommended under subsection
25 (b)(2).

1 “(d) The Advisory Committee shall consult with the
2 Health Care Financing Administration and private health in-
3 surance carriers concerning any changes in the rates of reim-
4 bursements for health services provided by physicians in
5 graduate medical education training programs and other
6 practicing physicians necessary to provide incentives to
7 achieve the goals recommended by the Advisory Committee
8 for the distribution of physicians by medical specialties.

9 “(e) The Advisory Committee shall submit to the Secre-
10 tary an annual report respecting the activities of the Adviso-
11 ry Committee. The Advisory Committee shall include in such
12 report a description of the consultations undertaken under
13 subsections (c) and (d).”.

14 (b) A member of the Graduate Medical Education Na-
15 tional Advisory Committee established by the Secretary of
16 Health, Education, and Welfare on May 1, 1978, shall con-
17 tinue in office as a member of the Advisory Committee estab-
18 lished under subsection (a) for the term of office prescribed
19 for that member at the time of the member's appointment.

97TH CONGRESS
1ST SESSION

H. R. 2056

To amend the Immigration and Nationality Act with respect to alien graduates of foreign medical schools.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 24, 1981

Mr. RODINO (for himself and Mr. WAXMAN) introduced the following bill; which was referred jointly to the Committees on the Judiciary and Energy and Commerce

A BILL

To amend the Immigration and Nationality Act with respect to alien graduates of foreign medical schools.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That (a)(1) section 212 of the Immigration and Nationality
4 Act (8 U.S.C. 1182) is amended by striking out the semi-
5 colon at the end of paragraph (32) of subsection (a) and in-
6 serting in lieu thereof a period and the following: "For the
7 purposes of this paragraph, an alien who is a graduate of a
8 medical school shall be considered to have passed parts I and
9 II of the National Board of Medical Examiners examination

1 if the alien was fully and permanently licensed to practice
2 medicine in a State on January 9, 1978, and was practicing
3 medicine in a State on that date;”.

4 (2) Subsection (j)(1)(B) of such section is amended by
5 inserting before the semicolon at the end a period and the
6 following: “For the purposes of this subparagraph, an alien
7 who is a graduate of a medical school shall be considered to
8 have passed parts I and II of the National Board of Medical
9 Examiners examination if the alien was fully and permanent-
10 ly licensed to practice medicine in a State on January 9,
11 1978, and was practicing medicine in a State on that date;”.

12 (3) Section 602 of the Health Professions Educational
13 Assistance Act of 1976 (Public Law 94-484), added by sec-
14 tion 307(q)(3) of Public Law 95-83, is amended by striking
15 out subsections (a) and (b).

16 (b) Subsection (j) of such section is amended—

17 (1) by striking out “(including any extension of
18 the duration thereof under subparagraph (D))” in para-
19 graph (1)(C);

20 (2) by striking out “Commissioner of Education”
21 and “Secretary of Health, Education, and Welfare”
22 each place it appears and inserting in lieu thereof
23 “Secretary of Education” and “Secretary of Health
24 and Human Services”, respectively;

1 (3) by amending subparagraph (D) of paragraph
2 (1) to read as follows:

3 “(D) The duration of the alien’s participation in
4 the program of graduate medical education or training
5 for which the alien is coming to the United States is
6 limited to the time typically required to complete such
7 program, as determined by the Director of the Interna-
8 tional Communication Agency at the time of the alien’s
9 entry into the United States, based on criteria which
10 are established in coordination with the Secretary of
11 Health and Human Services and which take into con-
12 sideration the published requirements of the medical
13 specialty board which administers such education or
14 training program; except that—

15 “(i) such duration is further limited to seven
16 years unless the alien has demonstrated to the
17 satisfaction of the Director that the country to
18 which the alien will return at the end of such spe-
19 cialty education or training has an exceptional
20 need for an individual trained in such specialty,
21 and

22 “(ii) the alien may, once and not later than
23 two years after the date the alien enters the
24 United States as an exchange visitor or acquires
25 exchange visitor status, change the alien’s desig-

4

1 nated program of graduate medical education or
2 training if the Director approves the change and if
3 a commitment and written assurance with respect
4 to the alien's new program have been provided in
5 accordance with subparagraph (C).”, and

6 (4)(A) by striking out “(ii)” in paragraph (1)(B)
7 and inserting in lieu thereof “(ii)(I)”;

8 (B) by inserting, in paragraph (1)(B), “(II)” before
9 “has competency”, “(III)” before “will be able to
10 adapt”, and “(IV)” before “has adequate prior educa-
11 tion”;

12 (C) by striking out “December 31, 1981” in para-
13 graph (2)(A) and inserting in lieu thereof “December
14 31, 1983”;

15 (D) by striking out “and (B), of paragraph (1)” in
16 paragraph (2)(A) and inserting in lieu thereof “and
17 (B)(ii)(I) of paragraph (1)”;

18 (E) by inserting after “if” in paragraph (2)(A) the
19 following: “(i) the Secretary of Health and Human
20 Services determines, on a case-by-case basis, that”;

21 (F) by striking out the period at the end of para-
22 graph (2)(A) and inserting in lieu thereof the following:
23 “, and (ii) the program has a comprehensive plan to
24 reduce reliance on alien physicians, which plan the
25 Secretary of Health and Human Services finds, in ac-

1 cordance with criteria published by the Secretary, to
2 be satisfactory and to include the following:

3 " (I) A detailed discussion of specific prob-
4 lems that the program anticipates without such
5 waiver and of the alternative resources and meth-
6 ods (including use of physician extenders and
7 other paraprofessionals) that have been considered
8 and have been and will be applied to reduce such
9 disruption in the delivery of health services.

10 " (II) A detailed description of those changes
11 of the program (including improvement of educa-
12 tional and medical services training) which have
13 been considered and which have been or will be
14 applied which would make the program more at-
15 tractive to graduates of medical schools who are
16 citizens of the United States.

17 " (III) A detailed description of the recruiting
18 efforts which have been and will be undertaken to
19 attract graduates of medical schools who are citi-
20 zens of the United States.

21 " (IV) A detailed description and analysis of
22 how the program, on a year-by-year basis, has
23 phased down and will phase down its dependence
24 upon aliens who are graduates of foreign medical
25 schools so that the program will not be dependent

1 upon the admission to the program of any addi-
2 tional such aliens after December 31, 1983.”; and
3 (G) by inserting at the end of paragraph (2)(B) the
4 following: “The Secretary of Health and Human Serv-
5 ices, in coordination with the Attorney General and the
6 Secretary of State, shall (i) monitor the issuance of
7 waivers under subparagraph (A) and the needs of the
8 communities (with respect to which such waivers are
9 issued) to assure that quality medical care is provided,
10 and (ii) review each program with such a waiver to
11 assure that the plan described in subparagraph (A)(ii) is
12 being carried out and that participants in such program
13 are being provided appropriate supervision in their
14 medical education and training.

15 “(C) The Secretary of Health and Human Serv-
16 ices, in coordination with the Attorney General and the
17 Secretary of State, shall report to the Congress at the
18 beginning of fiscal years 1982, 1983, and 1984 on the
19 distribution (by geography, nationality, and medical
20 specialty or field of practice) of foreign medical gradu-
21 ates in the United States who have received a waiver
22 under subparagraph (A), including an analysis of the
23 dependence of the various communities on aliens who
24 are in medical education or training programs in the
25 various medical specialties.”.

1 (c) The amendments made by paragraphs (1) and (3) of
2 subsection (b) shall apply to aliens entering the United States
3 as exchange visitors (or otherwise acquiring exchange visitor
4 status) on or after January 10, 1978.

5 (d)(1) Section 101(a)(27) of the Immigration and Nation-
6 ality Act (8 U.S.C. 1101(a)(27)) is amended by striking out
7 "or" at the end of subparagraph (F), by striking out the
8 period at the end of subparagraph (G) and inserting in lieu
9 thereof "; or", and by adding after subparagraph (G) the fol-
10 lowing new subparagraph:

11 "(H) an immigrant, and his accompanying spouse
12 and children, who—

13 "(i) has graduated from a medical school or
14 has qualified to practice medicine in a foreign
15 state,

16 "(ii) was fully and permanently licensed to
17 practice medicine in a State on January 9, 1978,
18 and was practicing medicine in a State on that
19 date,

20 "(iii) has competency in oral and written
21 English,

22 "(iv) entered the United States as a nonim-
23 migrant under subsection (a)(15)(H) or (a)(15)(J)
24 before January 10, 1977, and

1 “(v) has been continuously present in the
2 United States in the practice or study of medicine
3 since the date of such entry.”.

4 (2) Section 245(c)(2) of such Act (8 U.S.C. 1255(c)(2)) is
5 amended by inserting “or a special immigrant described in
6 section 101(a)(27)(H)” after “an immediate relative as de-
7 fined in section 201(b)”.

8 (e) The Secretary of Health and Human Services, after
9 consultation with the Attorney General, the Secretary of
10 State, and the Director of the International Communication
11 Agency, shall evaluate the effectiveness and value to foreign
12 nations and to the United States of exchange programs for
13 the graduate medical education or training of aliens who are
14 graduates of foreign medical schools, and shall report to Con-
15 gress, not later than January 15, 1983, on such evaluation
16 and include in such report such recommendations for changes
17 in legislation and regulations as may be appropriate.

Mr. WAXMAN. Before I ask our first witness to come forward, I would like to recognize Mr. Broyhill for comments he might like to make.

Mr. BROYHILL. I thank you, Mr. Chairman. I am pleased to join you in holding these hearings today.

And at the outset, I will say that we want to work with you on this issue as well as other issues of concern to the Subcommittee on Health and Environment of the Energy and Commerce Committee. In the past we have generally had a bipartisan effort in working out these bills and addressing the health care needs of the country, and it is our hope we can continue that as we have in the past.

However, it is sad to note that because of the critical economic condition in which we find our country today, we are not going to be able to fund the programs in the health manpower areas at the levels that many of us would like or would desire. And of course, this applies to dozens of other programs that many have supported over the years.

There is a considerable difference between the bill that has been introduced here and the administration's proposed funding levels. It is my understanding, as you pointed out, that H.R. 2004 is either identical or nearly identical to the bill that was passed in the House last year. I supported that bill at that time; I would expect, as you have pointed out, for a variety of factors that a different bill will come out of the committee or out of the House this year.

I intend to look very closely at each program in the manpower area. I will consider all of the arguments that will be made by those who are involved in providing health care to the people of our country.

I also understand that you agree to hear the administration as to its intentions on specific recommendations for changes in the program at a later time, and that the administration bill be forthcoming in the very near future.

So I do appreciate your agreeing to afford Secretary Schweiker this opportunity to appear at a later date and to testify on the administration's bill. I hope that we can arrive at some workable compromise and that we will be able to have far more agreement than disagreement.

Thank you very much.

Mr. WAXMAN. Thank you. I appreciate those comments. I think it sets the right tone for deliberations in this area and for other items that will be on our agenda this year.

We look forward to the administration's recommendations and also look forward to approaching these issues in a bipartisan or nonpartisan fashion. Health care is not a partisan concern. It is one that we share, trying to do the best we can given the economic situations we face and the realities of the political process.

I thank you for your comments.

Our first witness is Dr. Robert Blendon, senior vice president of the Robert Wood Johnson Foundation in New Jersey. The Johnson Foundation has had a major interest in health care issues.

He is accompanied by Dr. Linda Aiken, an assistant vice president of the foundation. Dr. Aiken, we welcome you.

I request of you and others who will appear to testify that the testimony you give must be summarized. The written statements

will be made part of the record in their entirety. But we would like you to summarize.

When we have panels, I think that we can only allow 5 minutes and no more. Since you are coming before us alone with primary testimony, we will give you 8 minutes. I know it is not really enough time, but the members of the committee do want the opportunity to engage in discussion, questions and answers, so we can review the contributions made.

STATEMENT OF ROBERT J. BLENDON, SC. D., SENIOR VICE PRESIDENT, ROBERT WOOD JOHNSON FOUNDATION, ACCOMPANIED BY LINDA AIKEN, PH. D., ASSISTANT VICE PRESIDENT

Dr. BLENDON. Mr. Chairman, I thank you on behalf of the Robert Wood Johnson Foundation for inviting us to this session.

In order to make this relatively rapid, you will see we have put our remarks on eight cardboard slide tables that we prepared for Secretary Schweiker. Before I move through these tables, I would like to make, with the chairman's allowance, just one personal comment. That is, having been in the foundation field for about 10 years now, one of the things that always interests trustees is what-ever happened to their academic fellows that they supported years later. I have an unusual characteristic and that is, most of the senior people in private foundations have had their advanced training supported by the Rockefeller, Carnegie Foundations, et cetera. Almost all of my advanced training was supported by this committee, and I have never had a chance in the last 9 years to say three things:

One is, the fellowship totally changed my career choice.

Second, I have been devoted to public service ever since.

Third, I have found myself personally involved with the priority issues of this committee ever since the training in the mid-sixties.

And last, thank you.

Now, with that in mind, I want to switch very quickly and say that the Robert Wood Johnson Foundation has spent about \$400 million in the last 8 years concerned broadly with the access to medical care. The funds have been involved with the support of private professionals, health institutions, medical schools, public and municipal institutions, community organizations, et cetera.

For many of you, that has involved some contact, because many programs have been located in your districts. We have had 120 direct medical service projects. We have supported primary care residencies and a variety of outpatient and rural area programs.

As part of this \$400 million expenditure, about 2 years ago we decided, for our own purposes, to do a major review of all the studies that existed on what was happening on the access to medical care problem in the United States. There were five studies that we reviewed. Three were completely supported by the Federal Government and two were jointly supported by the Robert Wood Johnson Foundation and the Federal Government.

For our own purposes we did this analysis. And at the last minute we decided that, as a charitable process, we would publish the results of that. I believe we are here today testifying because

the results of our interpretation of this data has gained a great deal of publicity.

Let me summarize four points, and I will present the data very quickly. And my colleague, Dr. Aiken, knows exactly how this was done.

Point 1 is—and many Americans have missed this—in a decade we have had an enormous improvement in access to medical care for Americans. It is one of the fastest changes that anyone who likes to watch trends can see.

It looks, if you review the data, that it is primarily due to: (1) the medicare-medicaid program; (2) the extraordinarily rapid expansion of number of physicians; and (3), the new availability of institutional care, neighborhood health care centers, and outpatient clinics.

Point 2, if you look at the data, by 1990 we will have enough physicians, given current practice patterns, for most Americans to have a personal physician. Now, that statement does not deal at all with any of the specialists, such as ophthalmologists, only with the issue of a personal physician.

Point 3, in our review of the data we have identified a group of people that we are calling for our own purposes the structurally underserved. Now, to all of you that is quite familiar. That is labor economics jargon for the structurally unemployed. That is, a group of people in the economy who, regardless of how many jobs the economy generates, never get one.

There appear to be, and I will show you in the data, a share of the American population which looks like somewhere between 12 and 25 million, who irrespective of the number of physicians this country produces, without some direct intervention, will not get one.

Lastly, and I only mention this because we have been criticized for this, the publications I will show you are all based on the following assumptions:

One is that at least medicare and medicaid will support the cost of these services to 1990.

Two, that the projected physician supply occurs.

And three, that the growing institutional sources for primary care and physicians to work in them, that's neighborhood health centers, community clinics, outpatient departments, are there in 1990.

Given those four points, I will show you a set of tables, and then answer any questions.

Table 1, and every one of you I hope has this. It is in the back of the testimony. We will run them in exactly the same order. This essentially shows you one of the most dramatic findings, at least for a group in the private sector. That is, within the United States between 1964 and 1978 for the first time in history it appears poor people have been seeing physicians more frequently than nonpoor.

Now, to be clearly on the record, every study always shows that the poor have higher rates of illness than the nonpoor. However, in the history of the United States, and at least the data goes back to the 1930's, we have never reached the point where the poor had contact and had gotten into the system, with or without high rates of illness, at a higher rate.

The earliest we have is 1931 where, if I gave you this table, the poor would be seeing physicians 50 percent less than the nonpoor. So we have seen a dramatic change of bringing the poor into the system.

Now, this includes all the problems of the medicaid bills, emergency rooms, et cetera. I think the point we would make is it is like the problem of getting recent immigrants in the schools. The first problem is getting them in the schoolhouse door. The second is how you make sure the programs are adequate.

We have made a major improvement, but with far to go, with getting the poor into health care.

Table No. 2 has to do with the issue and its particular impact on the black community, particularly with the higher rates of mortality. We have not in fact seen as large a shift, but as you can see we have seen a major improvement in access to medical care and in narrowing of the gap between black and white that probably existed for most of the post-World War II period.

To show you this is not just a perception of interviewers, a similar perception appears in the black community poll in Newsweek this week in terms of major improvements in health care in the United States.

Table No. 3 shows you the area we have not done as well in the United States, because in fact it still remains a trickier problem, and that is in rural America. We still maintain a significant gap in the physician visits per person and appear to be having a lesser impact in small town America with the programs that have been enacted than in fact in urban America.

Now we are going to switch very quickly to two other studies, and the studies were not done for the questions you are asking, but I believe they provide some guidance. That is, the University of Chicago did a nationwide study which asked a sample of Americans whether or not they had a regular source of medical care, a doctor whom they could identify by name, and whether or not they were satisfied on a variety of questions.

The second study, which was done at the University of California, asked 10,000 practicing physicians randomly selected, essentially how many people did they believe they were caring for as their particular patients.

And what you see here is the estimates of the American public, with an oversample for Spanish speaking and black Americans; and on the other side the results of 10,000 physicians' perception.

What you see is from their point of view, in 1976 the public believes that 70 percent of them have a doctor by name that they can identify as their regular source of medical care.

If you look at physicians, in fact the figure in 1976 was much more conservative. They perceived 52 percent of the public were under care by them.

But let me show you the table that has created the controversy, because as part of this physician study we asked each physician by specialty to look at how many they were caring for. So in today's

world a family practitioner cares for about 1,000 people a year in terms of their complete medical care, as they see it.

So what we did was take the rising supply of physicians——
Ms. MIKULSKI. Doctor, is that 1,000 people or 1,000 families?

Dr. BLENDON. 1,000 people. We did this on a per person basis. That does not mean they do not see a much larger patient load. But when asked, do you believe you are providing the bulk of the care for this patient, it is 1,000 people the average practitioner thinks he is providing the bulk of the care for.

What we discovered in this survey is that a number of specialists believe that they are likewise, though smaller in number, serving as the personal doctor for a significant number of people. I think allergists are for about 300 people a year, and that is not uncommon. I think there is testimony here of cardiologists beginning to follow people over years.

What we did was take the mix of physicians that are projected under GMENAC to be in practice in 1990, multiply it by the current practice patterns in the United States today, take the results from 10,000 practicing physicians. And what you discover is that by 1990 about 94 percent of Americans, given current medical practice patterns, would probably, from the conservative point of view of the practicing physician, have a personal physician.

That physician for 73 percent would be a generalist, for 21 percent would be a specialist.

And so essentially it looks as if the supply of physicians, given the way physicians not theoretically should practice, but actually practice in American offices today, would be minimally adequate to cover the population.

Now, before we get further.

Let me introduce you to what we started to use as the term structurally underserved. That is, we went back to the University of Chicago study and looked at the group in the American population that appears not to continue to get physician care as a personal physician, even though the numbers of doctors go up. And what you see here is this is just the rise of physicians per population. Down here are the percent of people without a physician.

And what you see is a percent of rural Americans, a percent of low income Americans, and a percent of nonwhite Americans who do not in fact get a physician even though the supply appears to come out. We estimate from these numbers that that group ranges between 12 and 24 million.

I am going to close very quickly.

Ms. MIKULSKI. Low income, I would just like a definition of that, doctor. Are we talking about low income as including medicaid-medicare? Where do you see the working poor come in—you know, the cocktail waitress who is not covered by any type of health insurance program, the bartender? There are a lot of people who are just right on the margin and not covered by employment programs.

Mr. WAXMAN. Could we withhold the questions until after the presentation? Otherwise other members will want to jump in.

Ms. MIKULSKI. Fine. I just wanted to understand. Low income is a buzzword these days.

Dr. BLENDON. This is the last of the studies.

And this is, quickly, a study of inner city Charleston and Boston, its black inner city areas. This is a 5-year study and it is the percent of people in the inner city who use private physicians, outpatient departments and neighborhood health centers.

What I want to show you very quickly is that in a 5-year period there is a shift between neighborhood health centers and outpatient departments. There is no shift in the inner city to essentially private physicians.

Although Charleston has a ratio of physicians to population of 208 per 100,000, in the inner city this group moves between outpatient departments and neighborhood health centers. They do not get into the system.

The best example of this, because many of us are oriented to the Boston physician supply area, this is the same study in the city of Boston. What it shows you again, this is inner city Roxbury, is between a 5-year period, there's been a shift between neighborhood health centers and outpatient department, but in fact there has not been a shift to the private physician. That is, this population in Roxbury does not get access to the private system.

And I close with this one chart.

As you can see, when people talk about a physician surplus, they say, at 245, what will we do in the United States. I will point out to you, the city of Boston today has 600 physicians per 100,000 population, and in Roxbury that population in fact is completely dependent either on an outpatient department or a neighborhood health center.

So the point we wanted to make is it looks as if, for the average American, the physician supply is having an effect in gaining access. However, there is a group of the population we call the structurally underserved who are immune to the doctor supply increasing, and unless some institutional form of primary care is available, just like for the structurally unemployed, they will not get into the health care system.

Thank you, and Dr. Aiken and I will try to answer any of the technical questions.

[Testimony resumes on p. 126.]

[Dr. Blendon's prepared statement follows:]

Statement by Robert J. Blendon, Sc.D.

Prepared for presentation to
Subcommittee on Health and the Environment,
Committee on Interstate and Foreign Commerce,
House of Representatives

March 4, 1981

Mr. Chairman, my name is Robert J. Blendon. I am pleased to appear before you and this committee today. For the past eight years I have served as Vice President of The Robert Wood Johnson Foundation. Although I am testifying today as a private individual, I will draw heavily upon my experience at the Foundation.

In 1972, The Robert Wood Johnson Foundation chose as one of its principal objectives to assist groups and institutions that would try to improve people's access to general medical services--primary care, as it has been termed. In this regard between 1972 and 1980 we made grants totaling more than \$400 million, mostly relating to this concern.

What I will offer you today is some information about Americans' access to primary care services that I hope will be relevant to your deliberations about the need for training new health professionals in the future.

I will give evidence which indicates that significant gains have been made in improving the American people's access to care over the past ten years. The large increases in the numbers of doctors and public financing of medical care service have been the major reason for these gains. However, I will also

present data which suggests that substantial numbers of Americans--whom we have characterized as the "structurally underserved" continue to have problems. In many ways these individuals resemble the "structurally unemployed" who are unable to find work no matter how many job openings there are. These Americans, because of geographic, cultural, and other barriers have trouble getting mainstream personal medical care. Simply increasing the numbers of doctors in America has not been enough. For the structurally underserved, it takes something like the National Health Service Corps that can reach out and share with them the benefits of modern medicine.

My presentation draws on the findings of five research studies. Three were funded or conducted by the Department of Health and Human Services. The other two, initiated by The Robert Wood Johnson Foundation, also received federal assistance.

The three federally financed studies are the National Health Interview Survey conducted in 1978 by the National Center for Health Statistics, an earlier survey, also by the Center, in 1975, and an unpublished study of community health centers supported by the National Center for Health Services Research and Development and recently analyzed by Howard Freeman and Gerald Goetsch at the University of California, Los Angeles.

The fourth study was directed by Ronald Andersen and Lu Ann Aday at the University of Chicago. Designed to measure people's access to medical care, it is based on a 1976 survey of 7,787 individuals in 5,432 randomly selected households across the country.

The last study was conducted between 1973 and 1976 by a team at the University of Southern California (USC) under the direction of Robert C. Mendenhall. In this study, 10,000 physicians in 24 specialties kept log-diaries on all their activities over three-day periods. Among the results is a wealth of data telling us what doctors did in 400,000 patient encounters in hospitals, in the doctors' offices and by telephone.

With your permission, Mr. Chairman, I would like to submit for the record three major reports drawing on the results of the National Health Interview Survey and the University of Chicago and the University of Southern California studies.

Much of what my colleagues and I have written in the past few years has focused on the good news of those research studies. The first study--by the National Center for Health Statistics--clearly shows that the number of physician visits per person per year has risen dramatically in this country. As shown in Charts 1 and 2, this is particularly true for blacks and people with low incomes--both groups with heavy burdens of illness who historically have been poorly served medically. We have not been as successful in improving the care for rural Americans (Chart 3).

However, simply counting the number of visits people make to doctors each year is not sufficient. The term "physician visit" can mean many things. It can be a hurried visit to a "Medicaid mill" in which a patient is ping-ponged among a series of doctors, nurses and others to maximize reimbursement income. It can be hours spent waiting in a crowded, noisy hospital outpatient clinic for a few minutes with a doctor you've never seen before. At the other end of the scale--and far more desirable

personally and medically—is the kind of visit you and I are accustomed to: seeing a doctor we know by name and who knows us and our families. Implicit in this relationship is the physician's assumption of personal responsibility for attending to an individual's medical care needs.

The value of this kind of professional relationship between a patient and a specific physician is borne out in the University of Chicago study. Included in this study was the collection of information about people's recent illnesses and where they got their care. Using this information, Andersen and Aday found that people who get their care in a clinic, or from several physicians, see a doctor 18 percent less frequently than objective medical opinion indicates they should. People who have no regular source of care see doctors 42 percent less frequently than experienced physicians feel is necessary.

The importance of these finer details in what access to care means in human terms is what prompted the Foundation to initiate the University of Chicago and the University of Southern California studies.

As Chart 4 shows, the University of Chicago study found that 78 percent of Americans in 1976 had a personal physician whom they could identify by name. At the same time, the University of Southern California survey of physicians indicated that physicians view themselves as principal providers for 62 percent of Americans. Thus the number of Americans who do not have a personal physician meeting their primary care needs is somewhere between these two figures. This translates into somewhere between 46 million and 79 million people.

The difference in apparent shortfall between the two studies is not as great as it may seem. The "78 percent" reflects people's perceptions of what they have available to them. On the other hand, the "62 percent"

reflects an actual use of services from the doctors' point of view. In addition, this projection was made early in the analysis, and was based on data that did not include some of the more hospital-based specialties and subspecialties. Thus, the two studies are mutually quite supportive.

We then coupled the results of the University of Southern California study with data on projected population growth and the output of doctors from U.S. medical schools. This has enabled us to estimate the capacity of the country's increasing supply of physicians to meet the primary care needs of the American people over the next decade (Chart 5). Because increasing numbers of doctors will enter practice in this period, the projections suggest that principal providers will be available for 85 percent of the population by 1985 and 94 percent by 1990.

However, we have other evidence that adding more physicians has not necessarily and may not in the future translate into better access to care for certain Americans. Let me take you back to the University of Chicago study and the 46 million people who said they were without a personal physician in 1976. For somewhat over one-half of these people, trouble finding a doctor was worrisome but not critical. They had to wait too long for an appointment, they had to travel too far, or they had problems paying the bill.

Of more importance to you, within this group there is a core of between 12 and 15 million individuals for whom the access problem is far tougher and more complex. Their access problems stem from a different set of reasons than those which confront most of us. These people face a series of non-health-related barriers which prevent them from getting to or receiving adequate care.

First, a number of them live in extreme geographic isolation, far from sources of care. Some reside in the backwaters of rural America or in seriously blighted inner-city areas. Poor public transportation, high crime rates, and lack of many basic public services all interrelate to create special problems of access to medical care for these people.

Second, for some, these problems are often coupled with the difficulties of cultural isolation. They do not speak English or they do not feel comfortable in traditional mainstream American medicine. These include certain groups of native Americans, Mexican emigrants and other Spanish-heritage peoples.

Third, despite Medicaid, poverty remains a barrier. Eligibility income levels have not been changed in most states in years, and with the rampant inflation we are experiencing, there has been a 25 percent decrease in the number of low-income people covered by public programs.

Fourth and finally, certain people remain outside the mainstream of medical care because they either move around frequently—including migrant laborers—or they reside in isolation from the rest of American life. These latter people, who were not surveyed in the University of Chicago study, are the 2.3 million Americans who live in institutions. Many studies have documented the inadequate provision of primary care services for people in homes for the aged, mental institutions, correctional facilities, and other institutions.

These 12 to 15 million Americans I have been describing constitute what I earlier termed the "structurally underserved." I say this because these people in the past have been unable to get a personal physician despite increases in the number of doctors practicing in America.

Let's look at the evidence. Chart 6 shows that despite the increasing number of doctors, between 1963 and 1976, little or no improvement was made in the number of blacks, or people with low-incomes, or rural residents who had a personal physician. A trend line is not available for Mexican-Americans in the Southwest, but spot data show that they too are among the structurally underserved groups.

A similar pattern can be seen in the inner-cities of America. A Charleston, South Carolina study, for example, shows that inner-city residents receiving their care from private physicians decreased 21 percent between 1969 and 1975. This despite the fact that the number of physicians per 100,000 people increased by 10 percent during this same period (Chart 7).

Boston presents an even more interesting case. Here, between 1971 and 1975, the percentage of inner-city residents (in the area studied) who had a personal physician declined 4 percent despite a 7 percent increase in the nationwide physician-to-population ratio (Chart 8).

What makes Boston so relevant to my thesis, however, is the physician-to-population ratio there. At this time there are 609 practicing doctors in Boston for each 100,000 residents--more than twice the ratio projected for country in 1990 (Chart 9).

This and other trends I have cited for the structurally underserved lead me to conclude that we have no solid basis for believing that the greatly increased number of physicians we will have in this country in 1990 will necessarily make personal physician care available for these special groups of Americans.

We are going to have to do something different than we have in the past if we want to provide access to a personal physician for:

- people with low incomes,
- the geographically isolated,
- the culturally isolated,
- and institutionalized Americans.

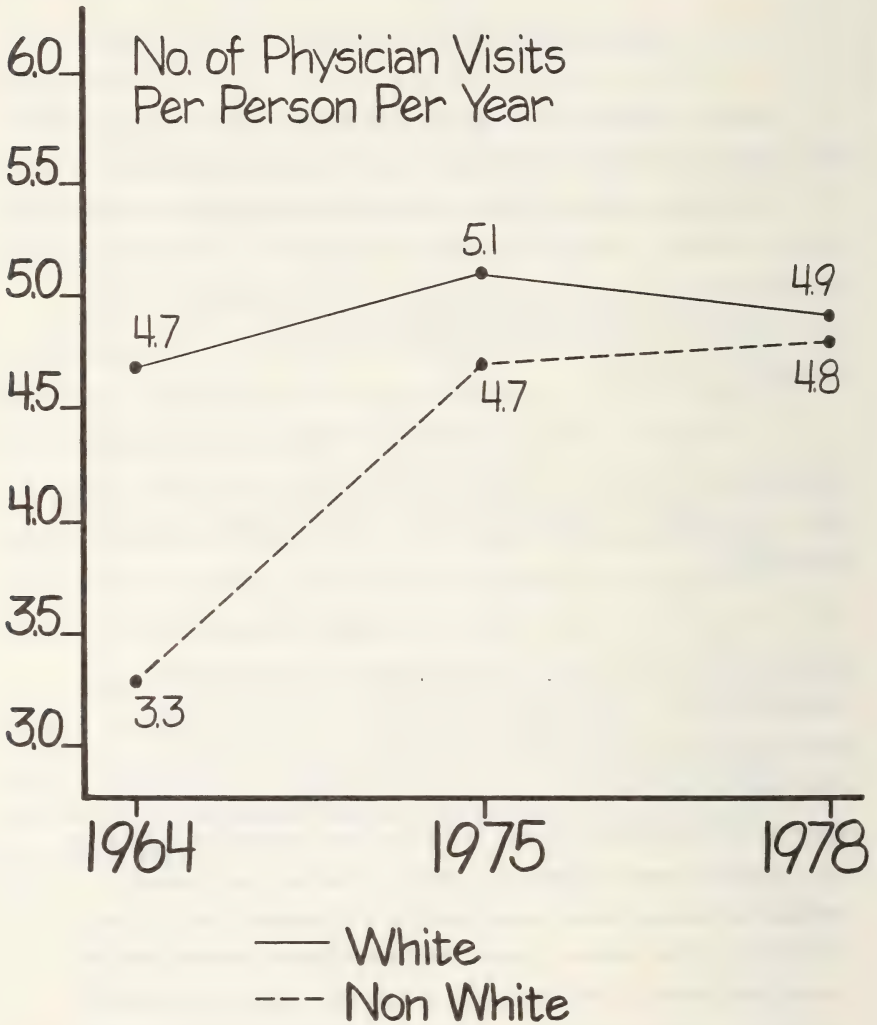
Medicare, Medicaid and graduating more and more doctors is simply not enough. The studies I have described make it appear probable that we will have adequate numbers of doctors to serve all Americans by 1990. But the other evidence I have cited suggests that we will also need special mechanisms and arrangements to ensure that a sufficient number of them practice in places and ways that will make them accessible to the structurally underserved.

I will leave to others to share with you whatever evidence there is regarding the potential of the National Health Service Corps to meet this need, but at present it represents the major national attempt to deal with this problem.

I would like to close with a final comment. The studies that produced the information cited in my testimony today were both time-consuming and costly. The University of Chicago and the University of Southern California studies alone have received \$2.9 million from The Robert Wood Johnson Foundation and another \$1.8 million from the federal government. Offsetting such costs is the fact that information produced by health services research studies like these is essential for informed decisions on national health policy involving the expenditure of billions of dollars. Yet at present, federal funding for health services research is declining sharply. This trend will have to be checked and reversed if you and the others responsible for national health policy are to have the information you will need to make wise choices.

Mr. Chairman and members of the Subcommittee, thank you for this opportunity to share my thoughts with you today. I will be pleased to respond to any questions you may have.

PER PERSON PHYSICIAN VISITS: WHITE AND NON-WHITE 1964 - 1978



PER PERSON PHYSICIAN VISITS: POOR AND NON-POOR

1964 - 1978

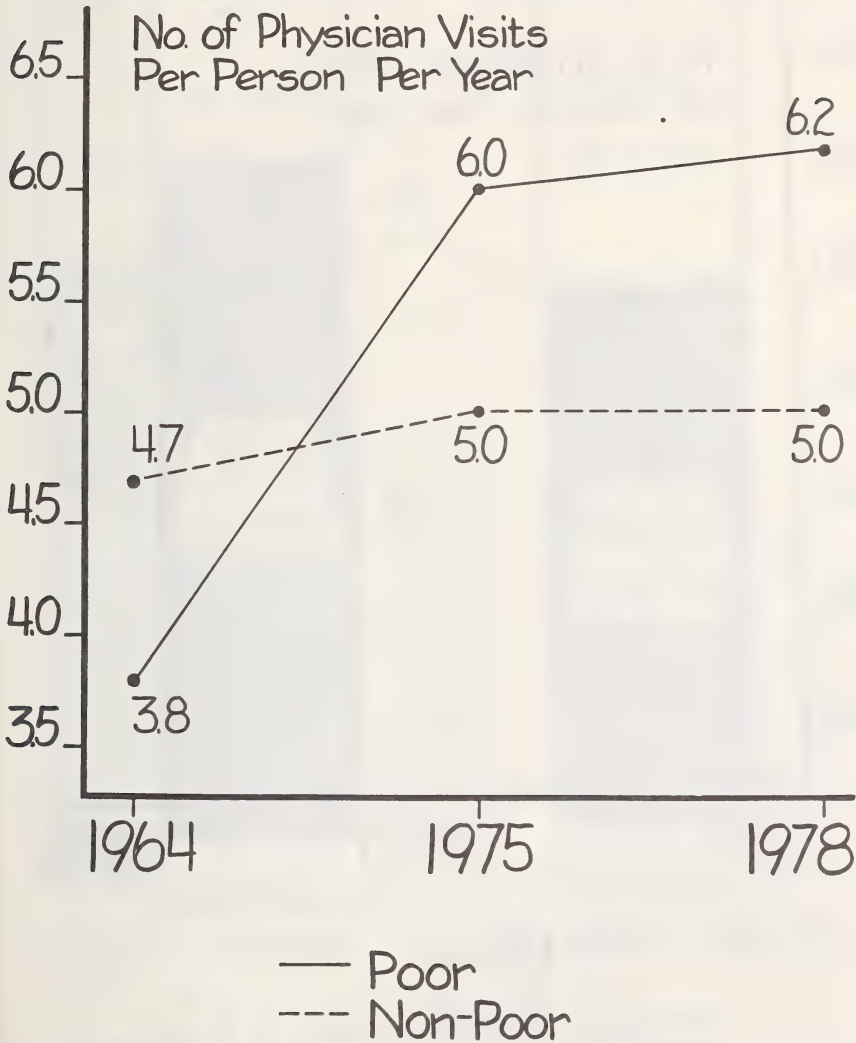


CHART 2

PER PERSON PHYSICIAN VISITS: URBAN AND RURAL RESIDENTS

1964 - 1978

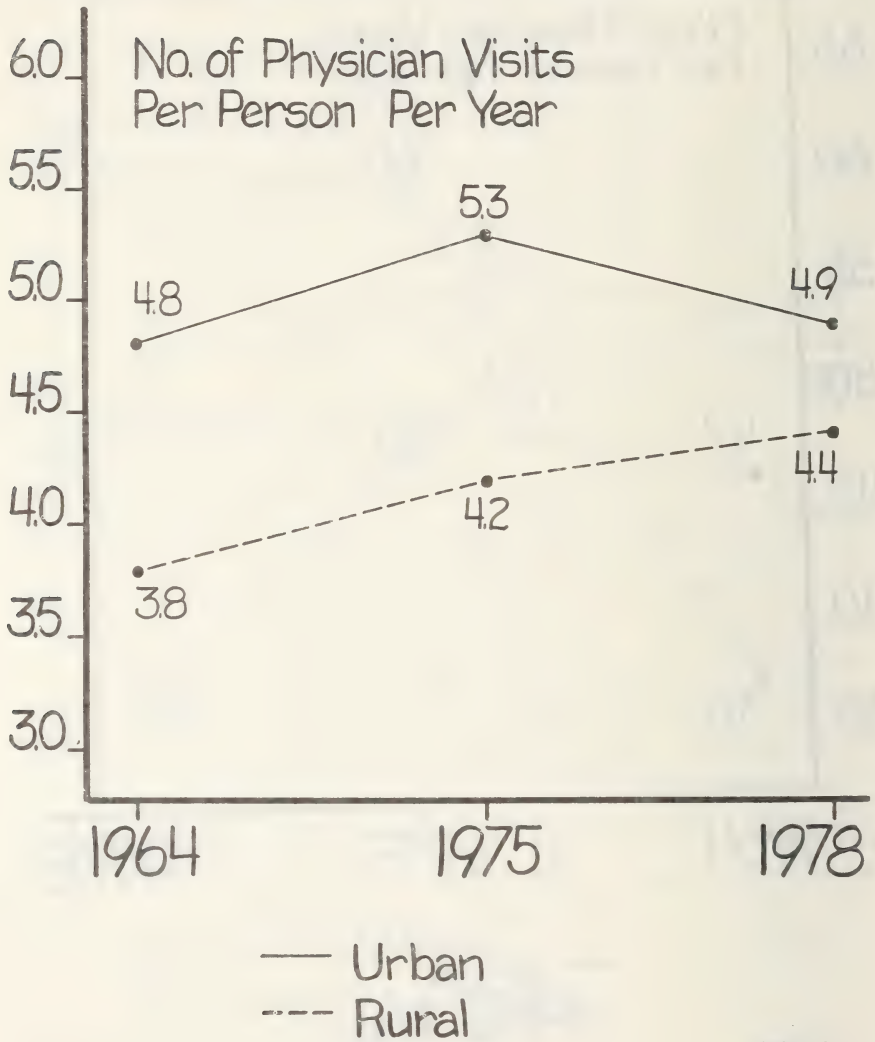
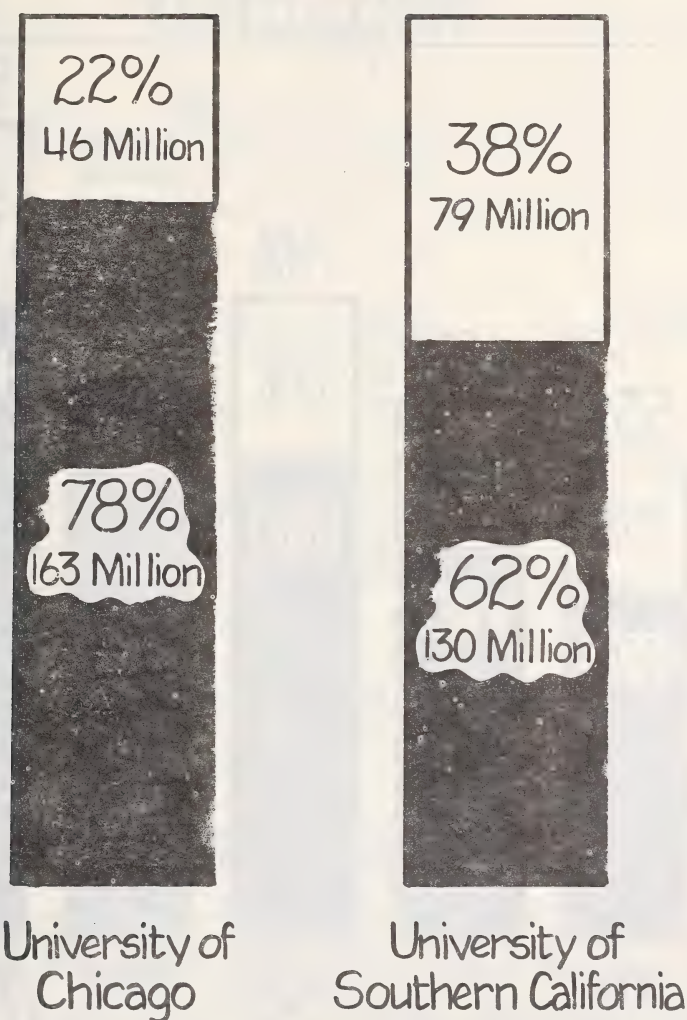




CHART 3

HOW MANY AMERICANS HAVE A PERSONAL PHYSICIAN?



 % Population Without a Physician
 % Population Having a Physician

AVAILABILITY OF PHYSICIANS — PAST, PRESENT, AND PROJECTED

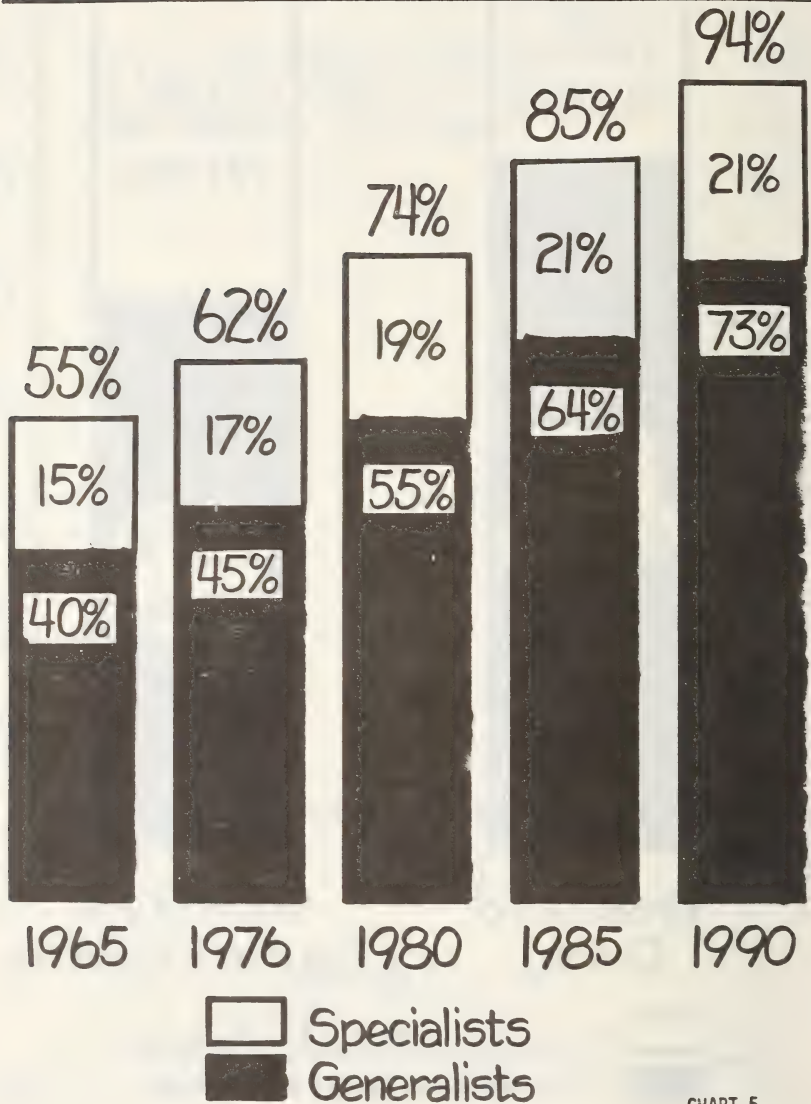
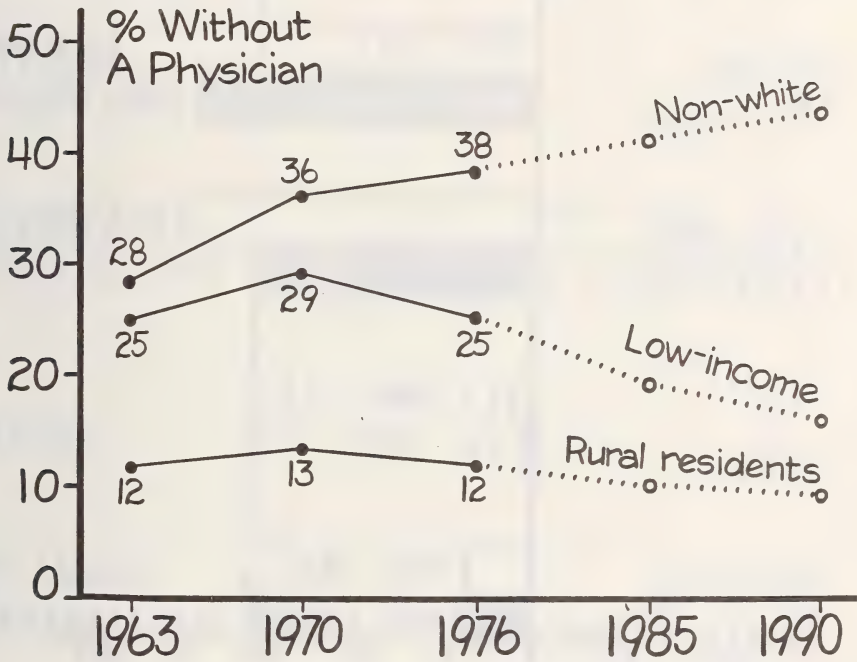
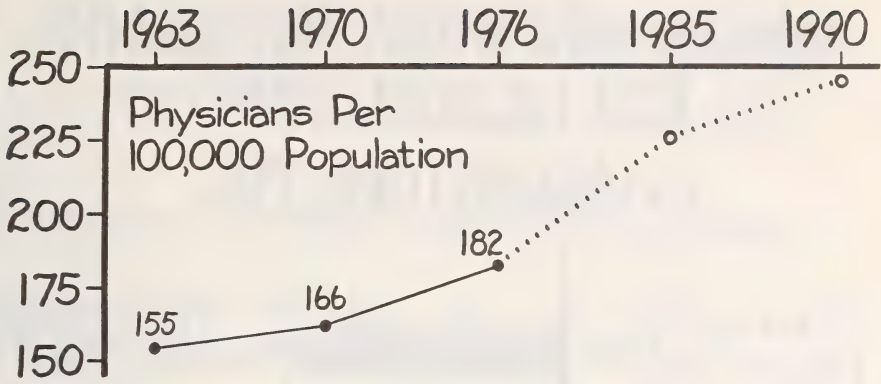
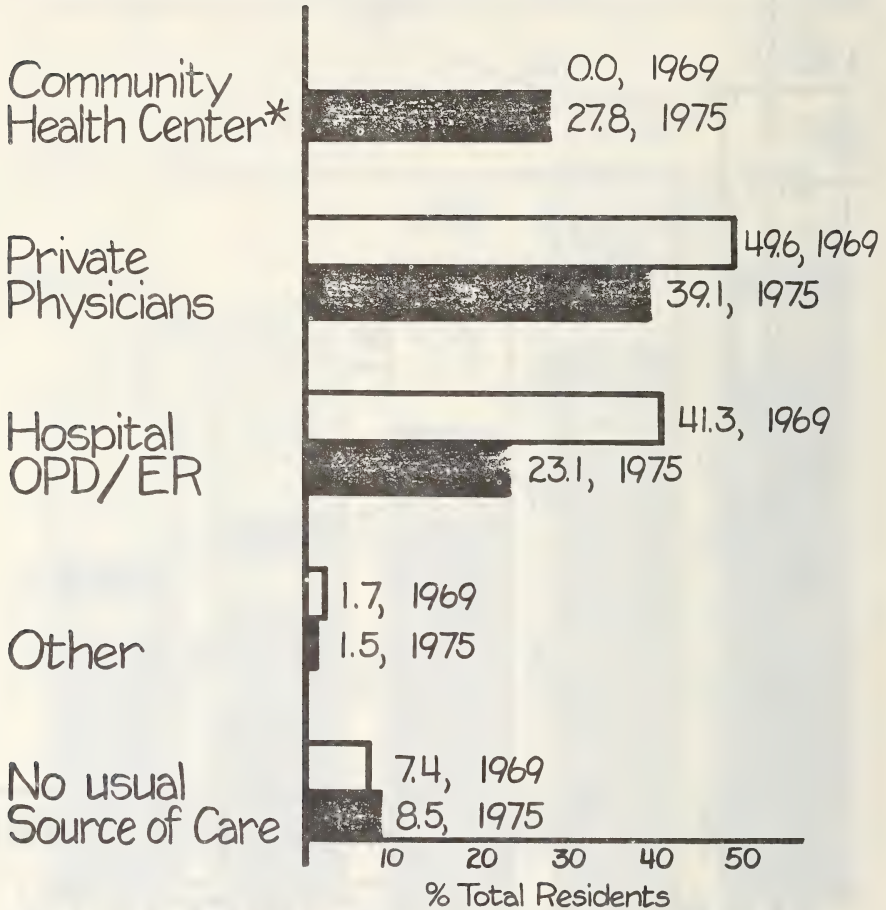


CHART 5



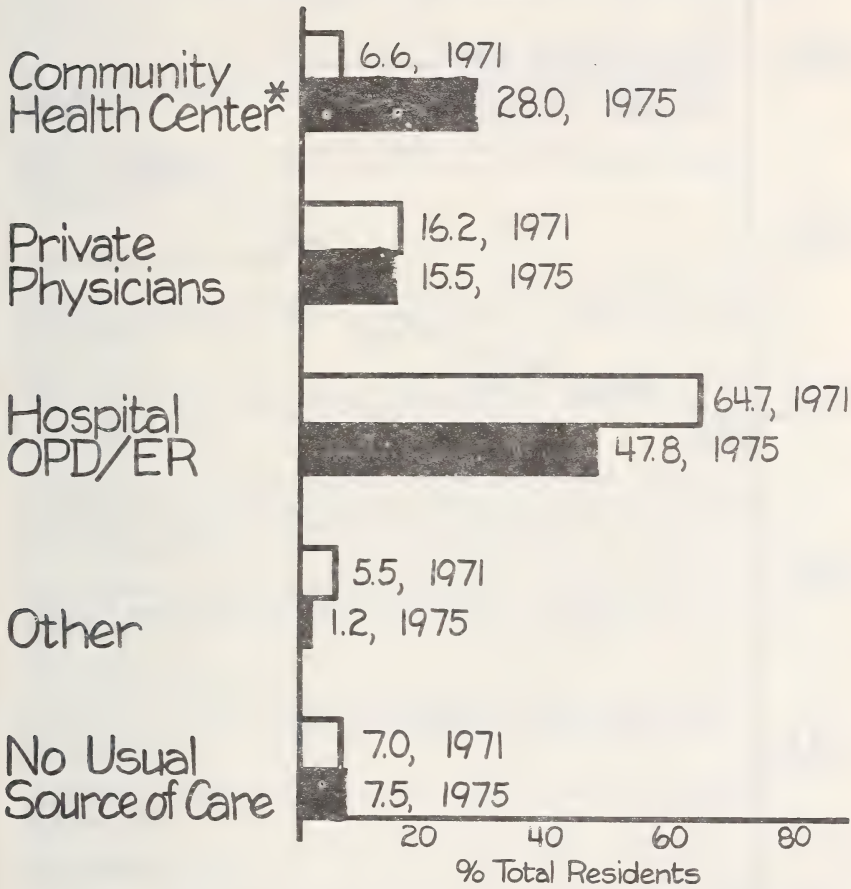
AMERICANS HAVING DIFFICULTY
GETTING A PERSONAL PHYSICIAN
1963 - 1976

WHERE INNER-CITY RESIDENTS GO FOR MEDICAL CARE — CHARLESTON, S.C.



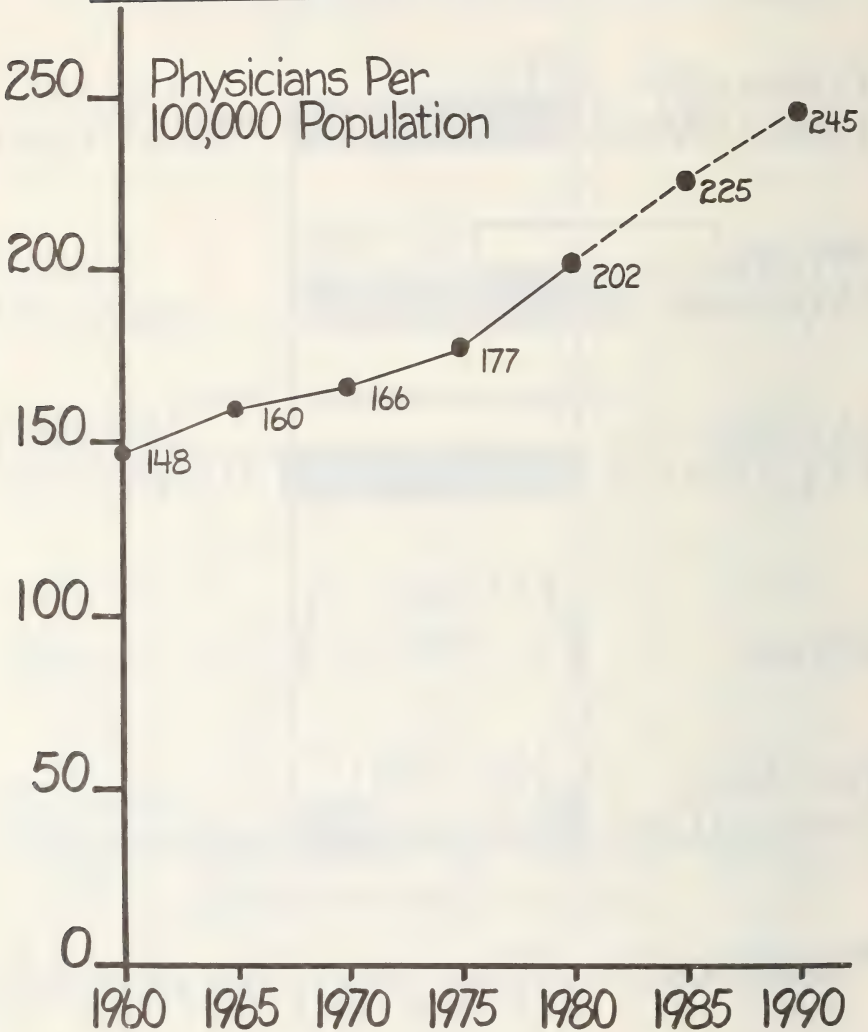
*Community Health Center began after study initiated

WHERE INNER-CITY RESIDENTS GO FOR MEDICAL CARE— BOSTON, MASS.



*Established in 1968

PROJECTED AND ACTUAL SUPPLY OF PHYSICIANS 1960 - 1990



REFERENCE SOURCES FOR CHARTS

Chart Numbers 1,2, and 3

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Linda H. Aiken et al, "The Contributions of Specialists to the Delivery of Primary Care," New England Journal of Medicine 300: 1369, 1979.

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Chart Numbers 7 and 8

Howard E. Freeman and Gerald G. Goetsch, Use of Community Health Centers, University of California, Los Angeles, (Los Angeles: Institute for Social Science Research, August 1980). Analysis based on data collected for the U.S. Department of Health, Education and Welfare, National Center for Health Services Research.

Chart Number 9

GMENAC Staff Papers, "Supply and Distribution of Physicians and Physician Extenders," loc. cit.

GMENAC, "Interim Report," loc. cit.

Mr. WAXMAN. How many people do you figure are in the structurally underserved population?

Dr. BLENDON. We are talking 15 to 25 million, and the reason why it is so tentative is when we supported the study we thought the problem would look much larger, and therefore the questions were not as specific about who did not have a doctor, because we were sure the numbers would be so large.

So it looks from the data somewhere between 15 and 25 million.

Mr. WAXMAN. How would you distribute those between rural or inner city areas?

Dr. AIKEN. I think they are more heavily distributed in the inner city areas. But obviously in the rural areas it is also a problem, especially the isolated rural areas.

Mr. WAXMAN. In other words, you are telling us that even though we have an increase in the number of doctors, there is still large portions of the population that will not have access to physician services

Dr. BLENDON. It looks as if somewhere between 12 and 25 million never get in to the system and are dependent on some sort of outreach programs to get the care.

Mr. WAXMAN. Can we then expect that as the number of physicians increases over the next several years to come, that the number increase is not going to deal with the problem of the structurally underserved?

Dr. BLENDON. For this group, we believe you need some sort of programs aimed at primary care and encouraging physicians to go into these primary care practices. So for this group, we do not believe that the supply will grow.

For the vast bulk of Americans, the supply will show a difference in their access to medical care.

Mr. WAXMAN. I assume a large part of this is covered under medicaid. Why would not they be able to go to physicians under medicaid and have access to this increasing number of physicians totally?

Dr. BLENDON. Again, it appears, looking at the studies in Boston and Roxbury, with the addition of medicaid all the people do is go back between outpatient departments and neighborhood health centers. It looks as if, either for cultural reasons, crime reasons or medical reasons, the physicians do not move in and actively seek out that population.

They are either using institutions or will use neighborhood health centers.

Mr. WAXMAN. To a great extent we have relied on the National Health Service Corps to serve underserved areas. The law that we now have on the books has funded scholarships for medical students in exchange for service in underserved areas.

How effective has that been?

Dr. BLENDON. We are not in a position to assess that. About the best that we could say is, of the 120 medical care practices we have supported, probably 30 percent of them have corps physicians that have been assigned. They tend to be in the areas where, even though the doctor supply has increased, it has been difficult to put the physicians in.

So if you were our trustees and we reviewed for you the 120, if I laid out for you the slightly more desirable areas, for instance Nebraska, where there have not been small town physicians, but it is beautiful countryside, we have practices in some of those rural areas that are getting physicians.

But when you take a look at some of the tough areas in the South, some of the tough areas, for instance, in west Memphis, if we did not have the corps those programs which we support would not have attracted physicians. So it really has depended on the area.

But there is a whole group of communities that were underserved in 1972 which appear to have fewer problems, and they are attracting private physicians, but not the tough ones.

Mr. WAXMAN. Mr. Broyhill.

Mr. BROYHILL. I find interesting what you said a few moments ago with respect to some of the factors which are contributing to this lack of access to the system. You mentioned crime. You mentioned what else, transportation?

Dr. BLENDON. Geographic isolation, cultural problems, language problems, which might affect the ability of an average physician to either set up a practice or people to feel comfortable using him.

Mr. BROYHILL. I think that really leads right to the question. What can we do with respect to a national program to change those factors, if those are the factors that deny access to the system? What can we do to make changes in those areas?

It seems to me that those are strictly local to a great extent, a local problem.

Dr. BLENDON. In all humility, after our Chief Justice's speech I will never get broader than the health field.

I think if you look at the data, it is impressive that the neighborhood health centers and various community clinics have gotten to this population, have provided services, have shifted many of them out of what are outpatient departments or crowded emergency rooms.

So I think if you look at the data, some of the programs targeted on that group have gotten services, and by essentially having a large group of outreach workers. It is easier to provide security for five physicians in a larger group, having their own transportation. So in a sense some of the programs appear to have gotten into these tough areas.

We are supporting, with the U.S. Conference of Mayors and the American Medical Association, a program where mayors are trying to get the cities to set up primary care services in these areas and to sustain them in what are some very difficult problem areas.

Mr. BROYHILL. So what you are saying is you have to have special incentives of one kind or another to get the physicians to move into these areas? In other words, to organize clinics or group practices in those particular areas; is that what you are saying?

Dr. BLENDON. Yes.

Mr. BROYHILL. With the increased supply of physicians by 1990, assuming the operation of the normal law of supply and demand, a lot of these physicians will normally move into these areas.

Dr. BLENDON. That is why the data from Boston so impressed us. If you looked at that next to Israel, there is not a collection of

doctors of that volume anywhere. And the fact that if you live in Roxbury, the dependency on neighborhood health centers, with 608 physicians per 100,000, leads me to believe that when we hit 275 the spillover will not be in Roxbury.

That does not mean there will not be a lot of crowding in other places, but I think there are some tough places that that number will not affect. I think that for a lot of small town America or parts of cities, they will see their first physician without any help as a result of the overall supply.

Mr. BROYHILL. Well, it may be that you will come back before the committee at another time and give us your approach as to how you change the system in order to make it more competitive. That is not the subject of your discussion here today.

Dr. BLENDON. Actually, we have different perspectives on how this could be done. A lot of physicians would like to come before this committee and suggest different things that have come out around the country.

Mr. BROYHILL. Thank you, Mr. Blendon.

Mr. WAXMAN. Mr. Walgren.

Mr. WALGREN. I was curious about the basic assumption that people who will not receive, or are medically underserved, if they are perceived by somebody as not having a personal physician, and in that sense they do not have access to perhaps one type of medicine. But how effective is their access to outpatient clinics and how effective is their contact with neighborhood-based services? Is that not a form of medical service that can function properly?

Dr. BLENDON. The answer is yes. One of the things in one of the studies we did was, through the University of Chicago there was a panel of 100 physicians that developed an independent scale of symptoms that patients, if they had, should bring in and see a physician. And in support of the survey they asked patients across the United States, for instance, if a young child has a headache, do you bring this child to see a physician.

One of the things that came out quickly is that if you do not have a doctor you have some continuing relationship with, your response to those symptoms is really quite different. Your use of medical care differs by whether or not you have somebody in a continuing relationship you identify with.

That is, people who, based on medical standards, had symptoms who should get treatment were not. So one of the things we are suggesting is it is desirable that there be some relationship between a recognized health professional and an individual, based on that study.

Mr. WALGREN. That is the assumption I think we have to probably look at very carefully, because it may be that that is the way we are now functioning, but I question whether we should function that way.

And I don't know whether we can take this group of people particularly, given whatever their characteristics might be, and ask them to fit into a personal physician-served and even fee for service structure, which is what the physician structure presently is. And shouldn't we be wondering whether that's the direction we want to push these people in?

Dr. BLENDON. Well, part of that I would like to agree with. Part of the problem of the study is that if you knew there are people who are really getting superb care in an organized outpatient setting who cannot or are not relating to an individual doctor. We were unable in the questionnaire to separate out those from people who in most medical settings are described as ping ponged from the emergency room to an outpatient department to an emergency room back for a visit.

And so the question about whether or not you are having a continuing relationship with more than one physician, a group which might reflect a lifestyle change. I believe if you did another survey you could ask a couple of questions which would get at the fact that in the best of the well-organized primary care programs you do not see the same physician, but you have a team of people who know your records, who it is easy to talk to; that if a drug has been prescribed and you are having an adverse effect, you can call them and get a response.

That would be very difficult to do in many of today's emergency rooms. So it is that ability with a group of professionals to have them manage your problem which really affects the outcome of some of these treatments.

Mr. WALGREN. I would like to yield to the gentlewoman from Maryland.

Ms. MIKULSKI. Thank you.

I just want to follow up on the line of questioning Mr. Walgren is pursuing and the line of assumptions. You say increasing the supply of doctors has shown that it does not increase the availability of services to these structurally underserved. My question to you is, have you done any research that shows that increases in different types of physicians might increase different services?

For example, if you look at the overall pool, do women who have been recruited and serve under the Health Manpower Act tend to work in neighborhood health or on to Indian reservations, or whenever? Do scholarships given to minorities pay a special dividend because, rather than going off to specialize in the right earlobe, they go back to the community where they are from?

Have you looked into whether minority constituencies benefit from a public investment in the training of minorities?

Dr. BLENDON. We never thought you would ask. We have done an analysis, as I am sure others have been presented to the committee, of particularly different settlement patterns of minority physicians. There is a very different settlement pattern.

We would be quite willing to submit our analyses, which are from a series of published studies, to this committee afterward. My colleague has just done an analysis of that, of the disproportionate choice of women into the primary care specialties and the disproportionate choice of women who work in outpatient departments and neighborhood health centers. So we would be quite willing to submit that, although I believe this analysis has been presented in other forums. We used the paper for our own trustees.

Mr. WAXMAN. We will be pleased to receive this information and to make it part of the record of the committee.

Ms. MIKULSKI. Does this also include social class variables?

Dr. BLENDON. No. I have to tell the Congresswoman that the only study that really we were able to find which was not supported by us of exactly that question of people right above the poverty line, because they are the people often without the health insurance——

Ms. MIKULSKI. No, I am talking about social class variables with regard to the opportunity to pursue medical education. Do poor kids that get scholarships go back and help poor people? Was there any study along that line?

Dr. AIKEN. I do not think the research that we have been involved in has shown that relationship. It does show that rural residents are more likely to go back to rural America than to general population. Of course, blacks are more willing to go back and serve black populations. Women are more likely to work in salaried jobs and outpatient clinics.

But just the economic-social status has not been addressed directly.

Ms. MIKULSKI. I appreciate Mr. Walgren for his indulgence. I have to go have my picture taken. I am not sure if it is for a hit list or what. And I did not want to lose out on this opportunity. So thank you.

Mr. WAXMAN. Mr. Benedict.

Mr. BENEDICT. Dr. Blendon, it seemed to me as we worked through the charts earlier there was one chart that indicated that the poor have access to an average of six visits per year versus the more affluent. Has that line crossed somewhere?

Dr. BLENDON. Right.

Mr. BENEDICT. But yet, you are also indicating that you have 12 to 27 million who never see a physician. On the face of it, that is a contradiction. Can you help me with that? Who are the poor if they are not part of that?

Dr. BLENDON. The contradiction is two points. The poor on every survey have much higher illness rates, and so a substantial share of them are reflected in this. They have funds, physicians are accessed, and they are using care.

Within the poor there is now a group that appears not to get in. Our problem is we have just been saying there are poor and non-poor. And that is where we developed the structurally underserved. There are groups of families we cannot identify by characteristic who are not using these services.

The larger number primarily reflects the higher illness rates of those poor who are now using care. So there is some percent, and we took a cut down on something like 12 or 15 percent who look structurally underserved. That is, they appear not to develop those regular sources of care. But the bulk of the poor appear to be getting into the system. So that is why the 12 to 24 million is a smaller number than many others have used.

Mr. BENEDICT. Can you help me with how you arrive at that 12 million, then, or that range, with 100 percent variation?

Dr. BLENDON. In the University of Chicago study, 78 percent of people had a physician by name that they could name. And this has been done somewhat periodically.

What you see in the low income, this is the percent of low-income people in 1963 who had nobody they could name as a source

of care. You see some drop, so it is about 25 percent. So 75 percent are having some relationship with a source of care.

The reason why we have a variation in the estimates is that people who said they did not have a source of care, some said they went to an emergency room, they went to an outpatient department. Some said they did not need a physician. It was hard for us to cull out. And then some just said, I cannot find a physician.

So we could not cull out from that set of questions how many of them were people who were changing doctors, who were happy in outpatient departments, and how many were people who really needed it. So to be fair to everybody, we just took a low and a high out of that 22 percent of Americans and said it probably falls somewhere between 12 and 25 million.

If we were ever involved again, we would ask a series of much more specific questions about why do you not have a physician you are relating to, even if it is in a hospital.

Mr. BENEDICT. You indicated in your view we are educating in all areas of health professions adequate numbers certainly, but that we are not touching the problem of the medically underserved.

Would you recommend looking at changing the aid formula to focus more directly on these kinds of problems, rather than having a broad base where you were helping the children of physicians and upper income families equally with, who apparently do not address this need? Would it be sensible to be looking at that?

Dr. BLENDON. Our concern is trying to limit any recommendations to the Congress and rather just give a perception of the situation. And that is a perception that this group of people with extremely high illness rates will not benefit from.

Mr. BENEDICT. Part of the learning process is to get a viewpoint from another individual and I hoped that you would offer one.

Dr. BLENDON. I think our foundation has not taken a position on governmental policies, only our concern about this.

Mr. WAXMAN. Thank you.

Mr. Luken.

Mr. LUKEN. The problem seems to be stated this way. The urban inner city areas is where we are focusing, for black and/or poor.

Dr. BLENDON. In the rural areas also—12 to 15 percent.

Mr. LUKEN. You made a distinction in rural areas, I thought. You said you were finding in some of the rural areas perhaps a more attractive living environment and were having less of a problem. And the figures that show that the poor are now receiving generally more visits, are making more visits per year than the nonpoor. Yet, the black or nonwhite population is still making less. That would indicate also that the problem is in the inner city, since I assume that is where we find blacks.

Dr. BLENDON. Well, right. If you remember, this table, which was the visits between rural and urban populations, we still maintain a significant gap, even though the physician supply did increase significantly between 1964 and 1978. And then on this table we tried to suggest that it looks like between 1963 and 1976 there were at least 12 percent of rural residents who seem never to come into, in any sense, contact with a personal physician.

And what I was relating to you was our foundation's experience with various care programs we ran where the rural areas were

really attractive. And I do not want to be disparaging, but in some places weather, transportation, isolation, no hospitals, are more difficult.

So there are counties in the South where we have programs where we have seen very little movement. But there are counties in, say Nebraska, where we have seen private physicians move into the primary care programs, and that is the rural areas that are picking up the physicians. But there is within rural America some very tough geographic areas that do not look, in our perception, like they will benefit from the supply of the physicians. They would need some coaxing to get some reasonable services in those communities.

Mr. LUKEN. Can you say from your studies whether the private practitioner is moving in any numbers into the inner, underserved city areas? Is there any increased availability in the number of physicians reflected in any way in those areas?

Dr. BLENDON. Yes, there is an increase, and this is reflected by the number of people who say that the low, there is a low income and minority who say they have a private physician as a regular source of care. So there is some movement into these areas.

The problem is we often have defined them as very large areas, and some on the periphery people move in and in others there has been no movement at all.

Also, almost one out of four or five physicians are hospital-based. That is, they're either interns, residents, or full-time physicians at a hospital. And so increasingly you have inner city people and physicians coming together through this huge hospital capacity. So much of the inner city growth, the medical care has been physicians are either in training or many become full-time emergency room physicians, full-time physician in St. Mary's general outpatient department. And that is where so-called private physicians have been coming in contact with the inner city people, not necessarily in solo practices by themselves.

Mr. LUKEN. Could you define "primary care"? Is primary care care on a continuing basis by the same physician, as opposed to a one-time visit to that physician?

Dr. BLENDON. For our purposes, Dr. Tarlov follows us and I would gladly let him take a crack, since this was an issue with GMENAC. For our own use, we use the term that was used by the Commission early on, and it was essentially the idea that the physician who provides the majority of care for an individual person or family, and it is the majority care function that in fact is how we have been defining this for our purposes.

Mr. LUKEN. So it could be a specialist?

Dr. BLENDON. Yes. And actually, part of the findings in the study was that a large number of specialists devote a small share of their time to what would be considered by that definition primary care practice. They have taken on some group of people to provide the majority of their care, and it is a small group often, but they have taken them on and are serving for those people as the personal majority care physician.

Mr. LUKEN. They are serving their general health needs, rather than just a specialty.

Dr. BLENDON. Yes.

Mr. LUKEN. You're not talking about people with a particular ailment and therefore they go to one doctor. You're talking about specialists who treat their general maladies?

Dr. AIKEN. Yes. For example, medical subspecialties like allergists, for example. We know on the whole they may take care of 300 patients on a continuing basis, in addition to carrying a case-load of specialty care that's much greater than that. But for those 300 patients, they provide the majority of their care.

Mr. LUKEN. Thank you.

And thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Whittaker.

Mr. WHITTAKER. Thank you, Mr. Chairman.

I believe the primary concern today is more the availability of medical care, and I have been somewhat concerned about what appears to be an inordinate amount of surveying done in reference to identifying physicians by name.

In one of your graphs you relate 78 percentile. Would you share with us, to what additional percent would that figure rise if you included within it the number of people who felt they did have medical care available, even though they could not name a physician by name?

Dr. AIKEN. I think on this issue everyone that had a personal physician, could name them by name or their specialty. We used a very complicated mechanism to try to check this out. The 78 percent we reported had a basic idea of what their approximate name was, where the office was, the usual source of care.

But there are people who use multiple sources of care, if that is what you are asking. There are 17 percent of Americans that may use multiple doctors on an episodic basis.

Mr. WHITTAKER. So thereby the percentage would rise to 88 percent, leaving a remainder of 12 percent.

Dr. AIKEN. Which is probably the hard core of the problem. Those who use doctors for episodic care are primarily young, without a large burden of illness.

Mr. WHITTAKER. Doctor, you related, and I am fascinated by the reference of the structurally underserved category. Do you feel that some of this, quote, "lack of success" is more lack of will, not necessarily a lack of medical needs, on the part of those people to seek medical care?

Dr. BLENDON. One of the reasons, and this again was the dilemma, when we did the studies, what should we do with them? As a real life supporter of 120 medical practices around the United States, we could see in our own day to day business the problem that there were communities not benefitting from the supply of physicians. That is, the calls on the telephone: We are still looking for a pediatrician, maybe we need a National Health Service Corps.

These appeared to reflect not the willingness of people to seek care, but the ability of pulling physicians in. So it led us to believe that what the data are saying to us is it is not that people are not seeking care. There are areas that physicians will not, without some great deal of help, go into. And when they go in, most of our practices are seeing patients. I want to assure you, they are collecting revenues, they are seeing patients.

And so the ability of pulling physicians into certain communities, it's not just calling them inner city or rural.

Mr. WHITTAKER. Doctor, you did an excellent job of identifying the physician going into the area. But my question was more related to those structurally underserved individuals. Do they simply in some cases lack the motivation or will to seek those services? Are they more prone, just as in the unemployed category, to do their own home remedy type services, rather than to enter the mainstream of medical services?

Dr. BLENDON. Again, it was tough, because we could see this. What you do see is a very disproportionate number for instance, of Spanish-speaking Americans who are right up at the top of the chart of being unable to get services. I think that suggests a language problem, a cultural problem, and a difficulty of mainstream American physicians practicing in Spanish-speaking communities. It has been a problem, and Spanish-speaking people will not seek medical care.

I think it is probably a problem of getting physicians into that community. And the same thing with urban inner city blacks. I guess it is a gut feeling.

We have said, if we are involved in another survey again we will ask much more extensively, why is it you are not having this relationship.

Mr. WHITTAKER. Doctor, you mentioned in your testimony that the structurally underserved have remained relatively steady in spite of Government involvement, manpower efforts, and community health center constructions. And yet you testified that to serve these people we must continue to proceed.

And then in questioning by Congressman Benedict you related that the increased numbers of doctors in these areas will not necessarily elevate the services to those structurally underserved people. Can you resolve that conflict for me, please?

Dr. BLENDON. There are two points. There are people who have a regular source of physician care; and then the second is how often they go.

What we have seen is, let me take the how often; that the effects of more physicians, which means there is less waiting time, and the effects of medicare and medicaid, which provide purchasing power that never existed before, have taken people who had a regular source of care and are now using it more often.

We have within that population a percent of people who, regardless, never get hooked into any physician and are very low users. So there are two groups.

One of the effects of these programs has been to take people who had some source of care and let them go much more frequently. And if you look at the surveys, the people that we presented are the people who had all the chronic illnesses, infant deaths, mortality. And we expect they would go, if we removed the barriers, more frequently.

But also in these communities there is a population that is totally unaffected at the moment by most of these programs, the Boston and Charleston examples provide a small subset. It appears if they get in it will be an outpatient department or a neighborhood health center. And they do not look likely, despite the fact

that Boston has three times the 1990 national average, to ever get into a private doctor's office.

There is something about this population and private doctors that does not look like it is going to relate. But these are the people that have the high death rates and the high infant mortality. Thus we are concerned about that population.

Mr. WAXMAN. Mr. Shelby?

Mr. SHELBY. I would like to direct my question to the area you mentioned of oversupply. You used Boston as an example, as I understood it, of an oversupply compared to the rest of the Nation. But in a certain area there was an underserved area.

Of course, isn't this going to happen in just about any big metropolitan area, not just Boston and Charleston, S.C.? But what about Boston, say, and St. Louis? Did you compare anything like that, or Atlanta?

Dr. BLENDON. Unfortunately, the study that was done had six communities.

Mr. SHELBY. Which communities were they?

Dr. AIKEN. Atlanta and St. Louis was in this community.

Mr. SHELBY. Do you have the statistics on those two cities?

Dr. AIKEN. No. Unfortunately, the research was flawed, which is why we did not report it.

Mr. SHELBY. What other cities were used besides Boston, St. Louis, and Atlanta?

Dr. AIKEN. And Charleston.

Mr. SHELBY. OK.

Dr. AIKEN. But I think we could look at any city and see the same phenomenon. There is nothing different about Charleston or Boston. Most urban areas have a very high physician to population ratio.

But the point is if we looked in most of those inner city areas we would find that private physicians were not there even in the larger metropolitan areas that have a very high ratio of doctors to people.

Mr. SHELBY. As the supply of doctors continues to increase, and I hope it will, will that not necessarily push doctors into those areas? Is there not some evidence that they are going to areas they were not going into 5 years ago, rural areas, maybe some of the inner city areas? They might not live there, but they work there. I have seen some of it in Birmingham, Ala.

Dr. BLENDON. I think we completely agree, and that is where we are trying to narrow this down. It looks at our experience over at least 5 years. There is a range of urban and rural areas that did not have a physician that have gotten them.

But there appear to be areas that are untouched, and if you looked at the 5 years in Roxbury which we showed you, Boston has had a huge increase just in the 5 years, but it has not led to private physicians opening their offices in Roxbury. But I will bet there are places in the Boston area that have picked up private physicians.

And in my analogy, there are places in Nebraska that we support that in 1972 we'd take an ad in JAMA and nothing would happen.

Mr. SHELBY. Some counties wouldn't even have a doctor, right?

Dr. BLENDON. Right. But it looks like there are spots in this country that will remain untouched at the 225 level, and you have really got to do something if you really want to get at those communities.

Mr. SHELBY. Some of the people, though, on our committee who talk about the competition in the marketplace all the time on different issues, would it not be the logical extension that the more doctors then the forces of the market come into being in the economic sense and doctors would on their own initiative be forced into these areas to make a living?

Dr. BLENDON. I think it is only on the data. We are supporting Eli Ginsberg, professor of economics at Columbia, who was chairman for about 10 years of the President's Commission on Manpower Policy, to follow the trends to see whether or not this was happening.

There really is, and I am sure Dr. Tarlov and others will express it, absolutely two different schools of thought: A group that feels that they will never come near these communities and a group that thinks in 1990, in desperation, that they will.

Mr. SHELBY. Like I am thinking.

Dr. BLENDON. I did not want to identify anybody with a group.

Our experience in looking at the Boston-Charleston data is there are sections of America it does not look like will be touched, but there are areas that will be. So we think that part of America, is the same issue, and the reason why we picked the terms up at another committee at another time, people will be saying, "If we only raise the new job rate, do you not believe these black teenagers would work?"

And somebody has sat in this very hall and said: "No, I do not think if you double the rate they will work." It is our belief in certain of these communities you will double the physicians and they will not see a doctor.

But for the bulk of America this is going to work out, in our belief, just as you suggest it is.

Mr. SHELBY. Mr. Chairman, if you will indulge one question.

You have said there are two schools of thought. A lot of times there are 8 or 10 schools of thought on this committee.

Mr. WAXMAN. That depends on whether there are 8 or 10 people here.

Mr. SHELBY. Are these schools of thought coming out of the so-called think tanks that we could get some data from, where they have done some studies, not flawed data, as Dr. Aiken said?

Dr. BLENDON. I am not sure, since we have had the first of these conferences under Dr. Ginsberg, that the data is available. I am sure he would be willing to testify. He is trying to write a summary piece right now. He has collected almost all the major groups, the American Medical Association and various think groups, to try to get their position on how they see it playing out in their specialty, in their communities.

He has gotten people from Kaiser. He is trying to poll various areas to see how they see it. And he is trying to write a summary paper for everyone on how people stand on this issue.

But sitting through this conference, you clearly could have drawn a line down the middle.

Mr. SHELBY. If he writes his paper, would you be kind enough to disseminate it to us?

Dr. BLENDON. Yes, sir.

Mr. WAXMAN. Mr. Dannemeyer?

Mr. DANNEMEYER. Dr. Blendon, you were kind enough to express your thanks earlier to the members of this committee for your education.

Dr. BLENDON. Absolutely.

Mr. DANNEMEYER. We are thankful for press any time we get it.

But let me make this observation: Neither the members of this committee or its predecessors gave you anything. The taxpayers of this country provided you the education that you thanked us for. If you want to thank somebody for it, thank the taxpayers.

Dr. BLENDON. I would like to, but you were one of the closest that I could find. But I thank the taxpayers very much for that education.

Mr. DANNEMEYER. You used the phrase 12 to 24. Was that million?

Dr. BLENDON. Yes.

Mr. DANNEMEYER. Can you tell us roughly what percentage of those are rural and urban residents? These are the people that the system does not seem to be serving with doctors. If you cannot——

Dr. BLENDON. We could take an approximate try for the committee later on in the records. We did not split it. We got an estimate of what proportion of rural America is underserved and urban, but we did not add them together. Again, on that one, it looked like about 13 percent of rural America never comes in contact with a regular source of medical care.

What we have not broken out is, we really would have to pull the rural residents and the low income out. So it is about 25 percent of low-income Americans fall into this, and about 12 percent of rural residents. But we have not calculated it exactly the way you have asked for.

Mr. DANNEMEYER. There is a little difference in the proposals the committee will have to consider this year in terms of the funding level required to produce all these physicians to serve all these people. For instance, our distinguished chairman has recommended a figure of \$2.845 billion and the administration is recommending a figure of \$1.111 billion, a slight difference.

And my question to you is, do you think we can fulfill our responsibilities in terms of the medical personnel necessary to meet our health care needs, at a funding level of \$1.111 billion?

Dr. BLENDON. We are not able to estimate that. We have enough trouble trying to figure out whether our funds can do what we want to do, without giving advice on the funding levels. We really have not worked on that. I could not answer that for you.

I do not know what level it would take to do that. Essentially, we backed into this out of our own primary care programs, without doing a study of Federal programs and the size or scale that would be necessary to get a job done.

Mr. DANNEMEYER. So you are not here to tell us that \$1.111 billion is inadequate, are you?

Dr. BLENDON. I do not have that answer. Either way you ask me that question, I could not adequately answer, because I honestly do not know.

Mr. DANNEMEYER. Thank you very much.

Mr. WAXMAN. Thank you very much, Dr. Blendon and Dr. Aiken. We appreciate the contribution you have made outlining this problem for us on geographical distribution.

We will now hear from Dr. Alvin Tarlov from the University of Chicago and Dr. Gerald Gehringer. Dr. Tarlov was the chairman of the Graduate Medical Education National Advisory Committee, GMENAC, and Dr. Gehringer is the chairman of the Board of the American Academy of Family Physicians.

I would like to welcome both of you to our meeting today. We would like to ask you to summarize your testimony in 5 minutes, so we will have an opportunity for questions.

STATEMENTS OF GERALD R. GEHRINGER, M.D., CHAIRMAN, BOARD OF DIRECTORS, AMERICAN ACADEMY OF FAMILY PHYSICIANS, ACCOMPANIED BY ROBERT YOUNG, M.D., AND ALVIN TARLOV, M.D., DEPARTMENT OF MEDICINE, UNIVERSITY OF CHICAGO

Dr. GEHRINGER. Mr. Chairman, I would like to introduce Dr. Robert Young, who accompanied me to the table. I hope you will allow that.

Mr. WAXMAN. Thank you, sir.

Dr. GEHRINGER. Mr. Chairman, I am Gerald Gehringer and I am representing the 50,000-member Academy of Family Physicians. And I will now summarize our written statement that you were given earlier. [See p. 141.]

Last year's testimony is already a matter of record and I will not repeat those views here. I would like to point out, however, that we have changed our thinking on one issue which was discussed last year. We previously supported combining sections 780 and 786 to avoid confusion, but further reflection has brought us to the conclusion that this is not a major issue.

We are appreciative of the concern you have shown regarding these programs in your new bill, H.R. 2004.

Last year we also spoke in support of establishing GMENAC as a statutory council, based on our impressions from that group's preliminary report. Now the final report has been issued and we can study the scope of their projections, we will reevaluate our Academy's position.

All of us here share an awareness of the overriding imperative of fiscal restraint. Since 1972 the Congress has been investing in family practice training, and we hope you recognize that this financial support has paid off in some very real results.

The first result is growth. The specialty of family practice started in 1969 with only 15 approved programs. By August 1980, 8,579 family practice residents had completed training, and there were 382 residency programs with an enrollment of 6,735 residents.

A second result is accessibility. Over the past 3 years an average of 49.7 percent of family practice residency graduates entered practice in communities with populations of 25,000 or less.

We believe this demonstrates that Federal dollars invested to date are showing a return in quality health care for growing numbers of Americans. The GMENAC report notes that:

Family practice residency training should be supported since these programs tend to train providers who are more likely to choose to practice in underserved areas.

The Academy agrees with this premise, but it is certainly not the sole rationale for continuing support. Given the fact that there are limited resources available to finance medical education, given the fact health care costs are escalating rapidly and there is a universal desire to contain such costs, and given the fact that the medical care system is becoming more complex, it becomes increasingly important in terms of cost effectiveness for each individual to have access to a personal family physician who has the training to assume responsibility for coordinating the health care on a continuing comprehensive basis.

Consider also that the balance for family practice physician supply and demand by 1990 are based on current data and maintenance of the status quo. If Federal funds are significantly reduced, the supply of new doctors in the system may decrease dramatically.

Federal funding is uniquely vital to family residency programs because the programs themselves are unique. They do not fit the traditional graduate medical education mold, that is, family practice education, in common with other graduate medical education programs, ultimately must be supported largely from patient care income. In family practice residencies, uncontrollable factors keep the costs high and the patient income low.

While traditional theory holds that approximately one-half of program costs should be recoverable through income from patient services, reality shows that to be an unrealistic expectation for family practice training. A national survey shows that the average family practice residency generated only 20 percent of the total patient costs.

We teach comprehensive preventive care in an ambulatory setting—a format critically different from traditional graduate medical education, which focuses on inpatient care. Third party reimbursement falls short as a foundation for family practice training because such coverage has a bias toward the inpatient care.

In addition, those procedures which are taught and performed in an inpatient residency are for the most part highly technical and expensive. Whether they are reimbursed by third parties or by individual patients, they generate large amounts of income, whereas those procedures which our educators are teaching young family doctors and which we believe contribute to better health and more cost-effective health care, such as preventive care, immunization and counseling, are relatively inexpensive, and as such cannot generate patient revenues sufficient to underwrite graduate training in family medicine.

The future of family medicine education is highly dependent upon a widespread understanding that its financing needs are different. Family medicine has been supported as a national priority with high standards for training and certification, a potential for overcoming maldistribution problems, and an emphasis upon ambulatory rather than expensive inpatient care. In a sense, these are

societal as well as program goals, and a continued sharing of the costs is essential.

Mr. Chairman, this concludes my statement. I thank you and I will be happy to answer questions.

[Testimony resumes on p. 154.]

[Dr. Gehringer's prepared statement and attachments follow:]

STATEMENT OF THE
AMERICAN ACADEMY OF FAMILY PHYSICIANS
BEFORE THE
ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT
MARCH 4, 1981

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM GERALD GEHRINGER, CHAIRMAN OF THE DEPARTMENT OF FAMILY MEDICINE AT LOUISIANA STATE UNIVERSITY SCHOOL OF MEDICINE IN NEW ORLEANS. I CURRENTLY SERVE AS CHAIRMAN OF THE BOARD OF DIRECTORS OF THE 50,000-MEMBER AMERICAN ACADEMY OF FAMILY PHYSICIANS.

JUST ONE YEAR AGO THIS MONTH, OUR FORMER BOARD CHAIRMAN DR. ERNIE CHANEY HAD THE OPPORTUNITY TO APPEAR BEFORE THIS SUBCOMMITTEE TO PRESENT THE ACADEMY'S RECOMMENDATIONS ON A NUMBER OF HEALTH MANPOWER-RELATED ISSUES INCLUDING MEDICARE AND MEDICAID REIMBURSEMENT, STUDENT ASSISTANCE AND THE NATIONAL HEALTH SERVICE CORPS, INSTITUTIONAL SUPPORT AND SPECIAL PROJECT GRANTS AND CONTRACTS. BECAUSE THIS SUBCOMMITTEE HAS ACCESS TO THE TRANSCRIPT OF THAT TESTIMONY AND WRITTEN STATEMENT, I WILL NOT REPEAT THOSE VIEWS HERE.

I WOULD LIKE TO POINT OUT, HOWEVER, THAT OUR ACADEMY HAS CHANGED ITS THINKING ON ONE ISSUE WHICH WAS DISCUSSED LAST YEAR:

THE COMBINING OF AUTHORITIES FOR SUPPORT OF FAMILY PRACTICE DEPARTMENTS IN MEDICAL SCHOOLS (SECTION 780 OF P.L. 94-484) AND FOR SUPPORT OF FAMILY PRACTICE RESIDENCY PROGRAMS AND PROGRAMS TO TRAIN TEACHERS OF FAMILY MEDICINE (SECTION 786(A) OF P.L. 94-484). WE PREVIOUSLY SUPPORTED COMBINING THESE SECTIONS INTO A SINGLE AUTHORITY TO AVOID CONFUSION, BUT FURTHER REFLECTION HAS BROUGHT US TO THE CONCLUSION THAT THIS IS NOT A MAJOR ISSUE. THE AAFP IS NO LONGER SEEKING SUCH A CONSOLIDATION.

ONE OTHER ELEMENT OF LAST YEAR'S TESTIMONY SHOULD, PERHAPS, BE UPDATED. AT THIS TIME LAST YEAR OUR ACADEMY SPOKE IN SUPPORT OF ESTABLISHING THE GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COUNCIL (GMENAC) AS A STATUTORY COUNCIL, BASED ON OUR IMPRESSIONS FROM THAT GROUP'S PRELIMINARY REPORT. NOW THAT THE FINAL GMENAC REPORT HAS BEEN ISSUED AND WE CAN STUDY THE SCOPE OF THEIR PROJECTIONS, OUR COMMISSION ON LEGISLATION AND GOVERNMENTAL AFFAIRS WILL RE-EVALUATE OUR ACADEMY'S POSITION AS TO THE NECESSITY FOR STATUTORILY PERPETUATING A NATIONAL COUNCIL ON GRADUATE MEDICAL EDUCATION.

ALL OF US HERE TODAY SHARE AN AWARENESS OF THE OVERRIDING IMPERATIVE FOR FISCAL RESTRAINT. OUR ACADEMY RECOGNIZES THAT THIS CONSIDERATION MUST TOUCH HEALTH MANPOWER AS IT TOUCHES EVERY OTHER FEDERAL PROGRAM. SINCE 1972, THE CONGRESS HAS BEEN INVESTING IN FAMILY PRACTICE TRAINING, AND WE HOPE YOU RECOGNIZE THAT THIS FINANCIAL SUPPORT HAS PAID OFF IN SOME VERY REAL RESULTS.

THE FIRST RESULT IS GROWTH. THE SPECIALTY OF FAMILY PRACTICE STARTED IN 1969 WITH ONLY 15 APPROVED TRAINING PROGRAMS. THE MATERIAL APPENDED TO MY WRITTEN STATEMENT AS ATTACHMENT A SHOWS THAT BY AUGUST OF 1980, 8579 FAMILY PRACTICE RESIDENTS HAD COMPLETED TRAINING, AND THERE WERE 382 RESIDENCY PROGRAMS WITH AN ENROLLMENT OF 6,735 RESIDENTS.

A SECOND RESULT IS ACCESS. SURVEY DATA WE HAVE COLLECTED SINCE 1975 SHOWS THAT RESIDENCY PROGRAM GRADUATES ARE LOCATING THEIR PRACTICES IN RURAL AS WELL AS URBAN AREAS. THE FIGURES IN ATTACHMENT B OF MY WRITTEN STATEMENT SHOW THAT OVER THE PAST THREE YEARS, AN AVERAGE OF 49.7% OF FAMILY PRACTICE RESIDENCY GRADUATES ENTERED PRACTICE IN COMMUNITIES WITH POPULATIONS OF 25,000 OR LESS.

WE BELIEVE THESE FIGURES DEMONSTRATE THAT FEDERAL DOLLARS INVESTED TO DATE ARE SHOWING A RETURN...IN QUALITY HEALTH CARE FOR GROWING NUMBERS OF AMERICANS. WE ARE SUPPORTED IN OUR BELIEF BY THE GMENAC REPORT, WHICH STATES THAT MEDICAL SCHOOL GRADUATES IN THE 1980'S SHOULD BE "STRONGLY ENCOURAGED TO ENTER TRAINING AND PRACTICE IN GENERAL PEDIATRICS, GENERAL INTERNAL MEDICINE AND FAMILY PRACTICE," EVEN IN LIGHT OF GMENAC PROJECTIONS THAT THERE WILL BE A "NEAR BALANCE" BETWEEN THE FAMILY PHYSICIAN SUPPLY AND DEMAND BY 1990.

THE REPORT OF THE GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COUNCIL GOES FURTHER TO SAY; "FAMILY PRACTICE RESIDENCY TRAINING PROGRAMS SHOULD BE SUPPORTED SINCE THESE PROGRAMS TEND TO

TRAIN PROVIDERS WHO ARE MORE LIKELY TO CHOOSE TO PRACTICE IN UNDERSERVED AREAS." THE ACADEMY AGREES WITH THIS PREMISE, BUT IT IS CERTAINLY NOT THE SOLE RATIONALE FOR CONTINUING SUPPORT. GIVEN THE FACT THERE ARE LIMITED RESOURCES AVAILABLE TO FINANCE MEDICAL EDUCATION, A SOUND INVESTMENT OF THESE RESOURCES IS IN FAMILY PRACTICE RESIDENCY PROGRAMS, WHICH WILL TRAIN PHYSICIANS TO TREAT THE VAST MAJORITY OF THE HEALTH PROBLEMS WHICH BESET MANKIND. GIVEN THE FACT HEALTH CARE COSTS ARE ESCALATING RAPIDLY AND THERE IS A UNIVERSAL DESIRE TO CONTAIN SUCH COSTS, THE PROMOTION OF FAMILY PRACTICE -- WITH ITS EMPHASIS ON PREVENTIVE, AMBULATORY CARE -- PROMOTES COST EFFECTIVENESS. GIVEN THE FACT THE MEDICAL CARE SYSTEM IS BECOMING MORE COMPLEX, IT BECOMES INCREASINGLY IMPORTANT IN TERMS OF COST EFFECTIVENESS AND HEALTH OUTCOMES FOR EACH INDIVIDUAL TO HAVE ACCESS TO A PERSONAL FAMILY PHYSICIAN WHO HAS THE TRAINING TO ASSUME RESPONSIBILITY FOR COORDINATING HEALTH CARE ON A CONTINUING, COMPREHENSIVE BASIS.

IN CONSIDERING FUTURE FEDERAL FUNDING FOR FAMILY PRACTICE, I WOULD ASK YOU TO CONSIDER THAT THE GMENAC PROJECTIONS FOR A "NEAR BALANCE" IN FAMILY PHYSICIAN SUPPLY AND DEMAND BY 1990 ARE BASED ON CURRENT DATA AND MAINTENANCE OF THE STATUS QUO. IF FEDERAL FUNDS ARE SIGNIFICANTLY REDUCED, THE SUPPLY OF NEW FAMILY DOCTORS ENTERING THE SYSTEM WILL NOT ONLY NOT REMAIN THE SAME BUT MAY DECREASE DRAMATICALLY.

FEDERAL FUNDING IS UNIQUELY VITAL TO THE OPERATION OF FAMILY PRACTICE RESIDENCY PROGRAMS BECAUSE THE RESIDENCIES ARE

THEMSELVES UNIQUE. THEY DO NOT FIT THE TRADITIONAL GRADUATE MEDICAL EDUCATION MOLD AND, AS SUCH, CANNOT LIVE UP TO WHAT ONE INDEPENDENT STUDY -- SOON TO BE PUBLISHED -- CALLS THE "UNSPOKEN EXPECTATION", THAT PRIMARY CARE EDUCATION, IN COMMON WITH OTHER GRADUATE MEDICAL EDUCATION, ULTIMATELY MUST BE SUPPORTED LARGLY FROM PATIENT CARE INCOME." THIS NEW STUDY DOCUMENTS WHAT FAMILY MEDICINE EDUCATORS HAVE BEEN FACING AS THEIR PROGRAMS STABILIZE FOLLOWING THE START-UP YEARS: UNCONTROLLABLE FACTORS KEEP COSTS HIGH AND PATIENT INCOME LOW. WHILE TRADITIONAL THEORY HOLDS THAT APPROXIMATELY ONE HALF OF PROGRAM COSTS SHOULD BE RECOVERABLE THROUGH INCOME FROM PATIENT SERVICES, REALITY SHOWS THAT TO BE AN UNREALISTIC EXPECTATION FOR FAMILY PRACTICE. A NATIONAL SURVEY IN 1975-76 BY THE HEALTH PLANNING RESOURCE CENTER AT THE UNIVERSITY OF WYOMING SHOWED THAT THE AVERAGE FAMILY PRACTICE RESIDENCY GENERATED ONLY 20% OF TOTAL PROGRAM COSTS THROUGH PATIENT REVENUES.

THE FAMILY PRACTICE RESIDENCY TEACHES COMPREHENSIVE PREVENTIVE CARE IN AN AMBULATORY SETTING -- A FORMAT CRITICALLY DIFFERENT FROM TRADITIONAL GRADUATE MEDICAL EDUCATION, WHICH FOCUSES ON INPATIENT CARE. THIRD-PARTY REIMBURSEMENT FALLS SHORT AS A FOUNDATION FOR FAMILY PRACTICE TRAINING BECAUSE SUCH COVERAGE HAS A BIAS TOWARD INPATIENT CARE. MEDICAL CONSUMERS WITH THIRD PARTY COVERAGE -- THROUGH THE GOVERNMENT OR PRIVATE CARRIERS -- ARE ENCOURAGED BY OUT-OF-POCKET COST CONSIDERATIONS TO USE INPATIENT SERVICES WHICH GENERALLY ARE FULLY COVERED. AT THE SAME TIME, THEY ARE DISCOURAGED FROM SEEKING AMBULATORY CARE WHICH, IF

COVERED AT ALL, OFTEN BURDENS THE CONSUMER WITH LARGE DEDUCTIBLES AND CO-INSURANCE PAYMENTS.

IN ADDITION, THOSE PROCEDURES WHICH ARE TAUGHT AND PERFORMED IN AN INPATIENT RESIDENCY PROGRAM ARE FOR THE MOST PART TECHNOLOGY-INTENSIVE, HIGHLY COSTLY PROCEDURES. WHETHER THEY ARE REIMBURSED BY THIRD-PARTIES OR BY INDIVIDUAL PATIENTS, THEY GENERATE LARGE AMOUNTS OF INCOME. THOSE PROCEDURES WHICH OUR EDUCATORS ARE TEACHING YOUNG FAMILY DOCTORS -- THOROUGH HISTORIES AND COMPLETE PHYSICALS.... THOSE PROCEDURES WHICH WE BELIEVE CONTRIBUTE TO BETTER HEALTH AND MORE COST-EFFECTIVE HEALTH CARE -- VACCINATIONS, PREVENTIVE CARE AND COUNSELING... ARE RELATIVELY INEXPENSIVE PROCEDURES AND, AS SUCH, CANNOT GENERATE PATIENT REVENUES SUFFICIENT TO UNDERWRITE GRADUATE TRAINING IN FAMILY MEDICINE.

TO QUOTE THAT RECENTLY COMPLETED STUDY WHICH I CITED EARLIER: "THE FUTURE OF FAMILY MEDICINE EDUCATION IS HIGHLY DEPENDENT UPON A WIDESPREAD UNDERSTANDING THAT ITS FINANCING NEEDS ARE DIFFERENT. FAMILY MEDICINE HAS BEEN SUPPORTED AS A NATIONAL PRIORITY WITH HIGH STANDARDS FOR TRAINING AND CERTIFICATION, A POTENTIAL FOR OVERCOMING MALDISTRIBUTION PROBLEMS, AND AN EMPHASIS UPON AMBULATORY RATHER THAN EXPENSIVE INPATIENT CARE. IN A SENSE, THESE ARE SOCIETAL AS WELL AS PROGRAM GOALS AND A CONTINUED SHARING OF THE COSTS OF TRAINING IS ESSENTIAL."

MR. CHAIRMAN, THIS CONCLUDES MY STATEMENT. I WOULD LIKE TO THANK YOU AND THE MEMBERS OF THE SUBCOMMITTEE FOR GIVING ME THE OPPORTUNITY TO PRESENT THE ACADEMY'S VIEWS. AT THIS TIME, I'LL BE HAPPY TO ANSWER ANY QUESTIONS WHICH YOU MIGHT HAVE.

ATTACHMENT ATentative Report
AAFP Reprint No. 150RESULTS OF ANNUAL SURVEY OF
FAMILY PRACTICE RESIDENCY PROGRAMS

August, 1980

I. Programs:

A. Total Approved Programs	382
B. Total Operating Programs (11 approved but not operating)	371
Community Hospital Based	57
Community Based & University Affiliated	187
Community Based & University Administered	49
University Based	62
Military Programs	16

II. Residents:

A. Total Residents	6,735
1. Total First Year Residents	2,365
2. Total Second Year Residents	2,295
3. Total Third Year Residents	2,075
B. Total Approved First Year Positions	2,536
C. First Year Fill Rate	93.2%
D. Increase/Decrease Class Size by Year	

	<u>1978-79</u>	<u>1979-80</u>	<u>1980-81</u>
Class of '81	*2,312	*2,206	2,075
Class of '82	—	*2,362	2,295
Class of '83	—	—	2,365

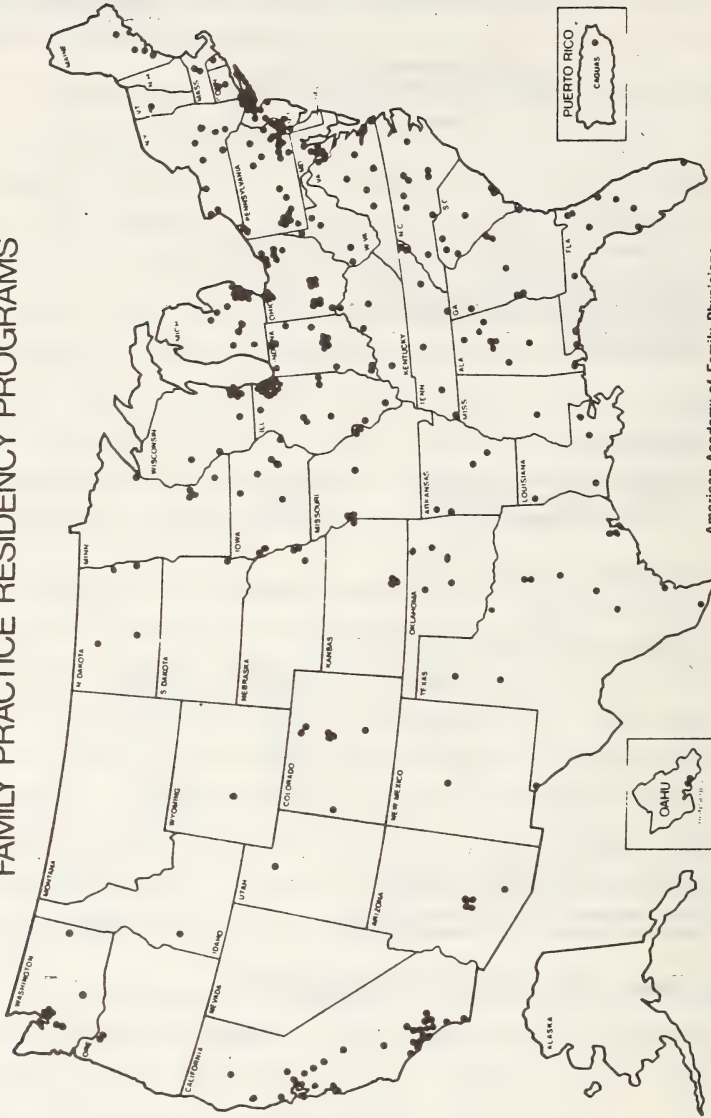
III. Residency Graduates:

A. Total July, 1980 residency graduates	1,846
B. Total graduates from family practice residency programs since January 1, 1970	*8,579

* - These figures reflect up-dated data from previous years

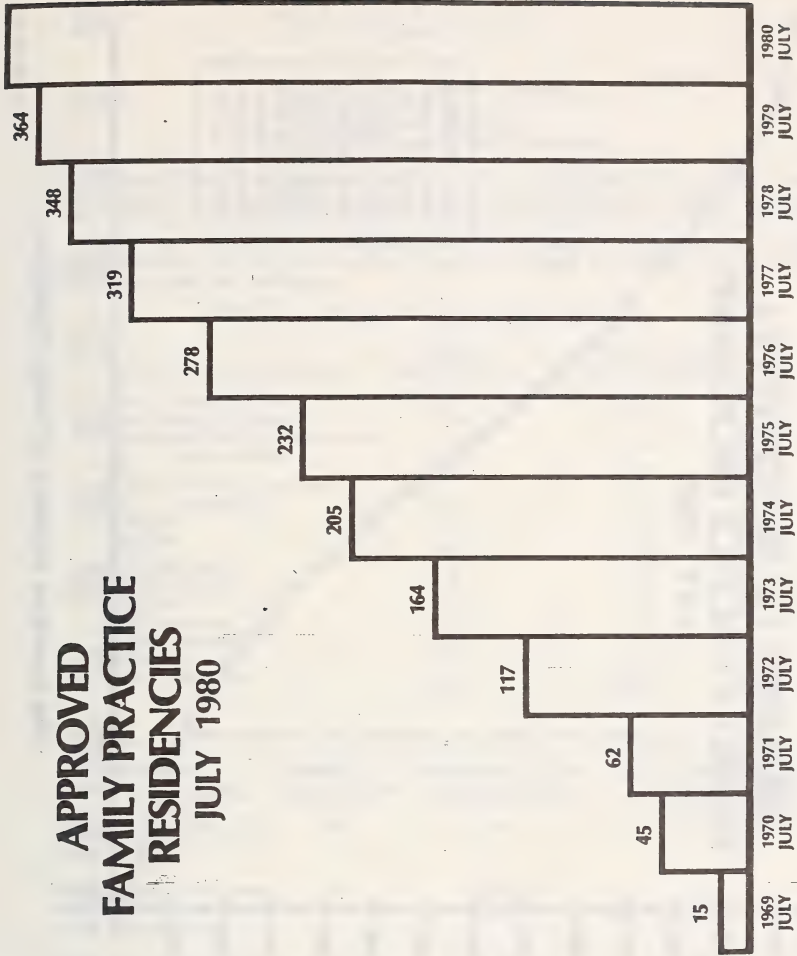
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FAMILY PRACTICE RESIDENCY PROGRAMS

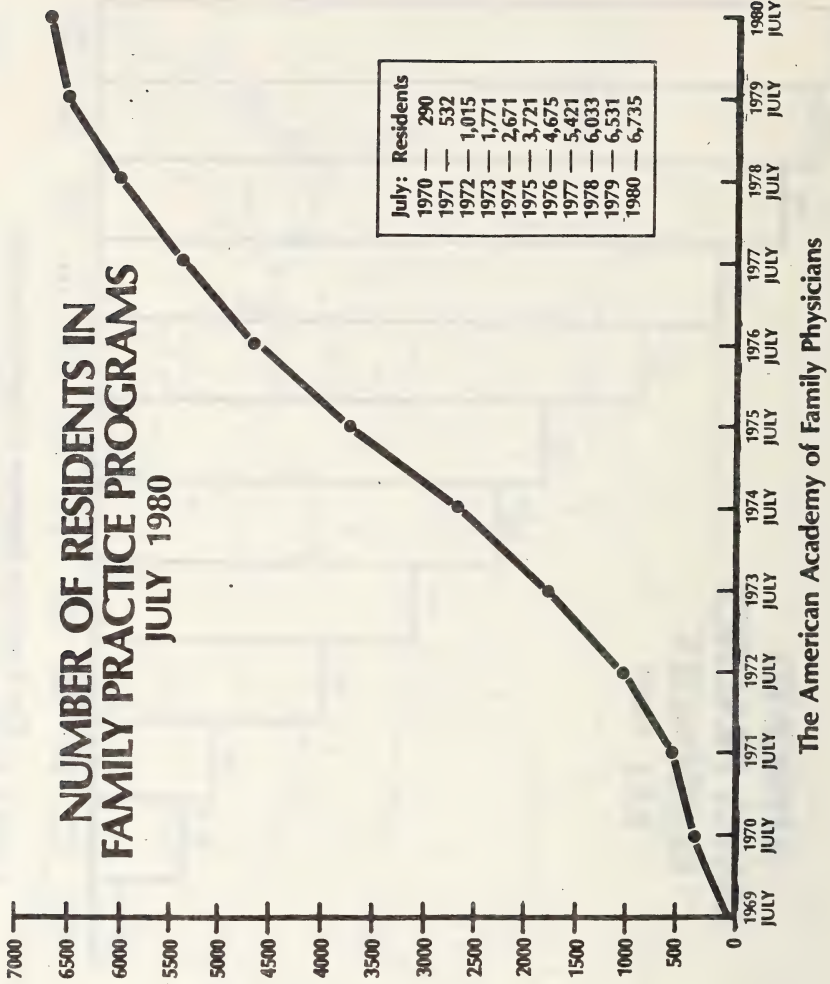


American Academy of Family Physicians

APPROVED FAMILY PRACTICE RESIDENCIES JULY 1980



The American Academy of Family Physicians



ATTACHMENT B

American Academy of Family Physicians

AAFP Reprint No. 155F

REPORT ON SURVEY OF
1980 GRADUATING FAMILY PRACTICE RESIDENTS

The total number of graduates surveyed was 1913. Of this number, 1707 (89.2%) responded. Of these respondents, 1602 indicated type of practice arrangement and 1337 specified the size of the community which they plan to serve. A summary of the results as of July, 1980, follows.

Caution must be exercised in comparing 1980 data with data from previous years because of changes made to data analysis. The data from previous years is being re-analyzed to conform with these 1980 statistics.

PRACTICE ARRANGEMENTS OF 1980 GRADUATING RESIDENTS

Type of Practice Arrangement	Number of Reporting Grads	Percentage of Total Reporting Grads
Family Practice Group	358	22.3%
Multi-Specialty Group	136	8.5%
Two-Person Family Practice Group (partnership)	283	17.7%
Solo	211	13.2%
Practice (arrangement not specified)	116	7.2%
Military	115	7.2%
Teaching	54	3.4%
USPHS	129	8.1%
Emergency Room	67	4.2%
Hospital Staff	28	1.7%
Research	1	.1%
Administrative	5	.3%
Further Training	33	2.0%
Fellowship	32	2.0%
None of the above	34	2.1%
	<u>1,602</u>	<u>100.0%</u>

DISTRIBUTION OF 1980 GRADUATING RESIDENTS BY COMMUNITY SIZE

Character and Population of Community	Number of Reporting Grads	Percentage of Total Reporting Grads	Cumulative Percentage of Total Reporting Grads
Rural area or town (less than 2500) not within 25 miles of large city :	106	8.0%	8.0%
Rural area or town (less than 2500) within 25 miles of large city	37	2.8%	10.8%
Small town (2500-25,000) not within 25 miles of large city	310	23.2%	34.0%
Small town (2500-25,000) within 25 miles of large city	200	15.0%	49.0%
Small City (25,000-100,000)	238	17.8%	66.8%
Suburb of small metropolitan area	50	3.7%	70.5%
Small metropolitan area (100,000-500,000)	134	10.0%	80.5%
Suburb of large metropolitan area	134	10.0%	90.5%
Large metropolitan area (500,000 or more)	78	5.8%	96.3%
Inner city/low income area (500,000 or more)	50	3.7%	100.0%
	<u>1,337</u>	<u>100.0%</u>	

American Academy of Family Physicians

REPORT ON SURVEY OF
1979 GRADUATING FAMILY PRACTICE RESIDENTS

The total number of graduates surveyed was 1724. Of this number, 1577 (91.5%) responded. Of these respondents, 1571 indicated type of practice arrangement and 1302 specified the size of the community which they plan to serve. A summary of the results follows.

Caution must be exercised in comparing 1977, 1978 and 1979 demographic data with demographic data from previous years because modifications were made in 1977 in the criteria describing character and population of communities to which graduating residents were moving to practice. However, 1977-1979 data may be directly compared with confidence.

PRACTICE ARRANGEMENTS OF 1979 GRADUATING RESIDENTS

Type of Practice Arrangement	Number of Reporting Grads	Percentage of total Reporting Grads
Family Practice Group	412	26.2%
Multi-Specialty Group	114	7.3%
Two-Person Family Practice Group (partnership)	257	16.3%
Solo	194	12.3%
Practice (arrangement not specified)	111	7.1%
Military	150	9.5%
Teaching	82	5.2%
USPHS	100	6.4%
Emergency Room	62	3.9%
Hospital Staff	26	1.7%
Research	1	.1%
Administrative	4	.3%
Further Training	44	2.8%
None of the above	14	.9%
	1,571	100.0%

DISTRIBUTION ON 1979 GRADUATING RESIDENTS BY COMMUNITY SIZE

Character and Population of Community	Number of Reporting Grads	Percentage of Total Reporting Grads	Cumulative Percentage of Total Reporting Grads
Rural area of town (less than 2500) not within 25 miles of large city	79	6.1%	6.1%
Rural area or town (less than 2500) within 25 miles of large city	38	2.9%	9.0%
Small town (2500-25,000) not within 25 miles of large city	320	24.5%	33.5%
Small town (2500-25,000) within 25 miles of large city	212	16.3%	49.8%
Small City (25,000-100,000)	207	15.9%	65.7%
Suburb of small metropolitan area	48	3.7%	69.4%
Small metropolitan area (100,000-500,000)	133	10.2%	79.6%
Suburb of large metropolitan area	121	9.3%	88.9%
Large metropolitan area (500,000 or more)	96	7.4%	96.3%
Inner city/low income area (500,000 or more)	48	3.7%	100.0%
	1,302	100.0%	

ANNUAL REPORT OF THE
 1978 GRADUATING RESIDENTS OF
 1978 GRADUATING RESIDENTS OF
 1978 GRADUATING RESIDENTS OF

The total number of graduates surveyed was 1548. Of this number, 1340 (86.5%) responded. Of these respondents, 1340 indicated type of practice arrangement and 1107 specified the size of the community which they plan to serve. A summary of the results follows.

Caution must be exercised in comparing 1977 and 1978 demographic data with demographic data from previous years because modifications were made in 1977 in the criteria describing character and population of communities to which graduating residents were going to practice. However, 1977 and 1978 data may be directly compared with confidence.

PRACTICE ARRANGEMENTS OF 1978 GRADUATING RESIDENTS

Type of Practice Arrangement	Number of Reporting Grads	Percentage of Total Reporting Grads
Family Practice Group	340	25.4%
Multi-Specialty Group	99	7.4%
Two-Person Family Practice Group (partnership)	241	18.0%
Solo Practice (arrangement not specified)	170	12.7%
Military	81	6.0%
Teaching	130	9.7%
USPHS	71	5.3%
Emergency Room	59	4.4%
Hospital Staff	48	3.6%
Research	24	1.8%
Administrative	2	.1%
Further Training	4	.3%
None of the above	29	2.2%
	42	3.1%
	1,340	100.0%

DISTRIBUTION OF 1978 GRADUATING RESIDENTS BY COMMUNITY SIZE

Character and Population of Community	Number of Reporting Grads	Percentage of Total Reporting Grads	Cumulative Percentage of Total Reporting Grads
Rural area or town (less than 2500; not within 25 miles of large city)	91	8.2%	8.2%
Rural area or town (less than 2500) within 25 miles of large city	31	2.8%	11.0%
Small town (2500-25,000) not within 25 miles of large city	260	23.5%	34.5%
Small town (2500-25,000) within 25 miles of large city	176	15.9%	50.4%
Small city (25,000-100,000)	189	17.1%	67.5%
Suburb of small metropolitan area	43	3.9%	71.4%
Small metropolitan area (100,000-500,000)	101	9.2%	80.6%
Suburb of large metropolitan area	103	9.3%	89.9%
Large metropolitan area (500,000 or more)	79	7.2%	97.1%
Inner city/low income area (500,000 or more)	32	2.9%	100.0%
	1,105	100.0%	

STATEMENT OF ALVIN TARLOV, M.D.

Dr. TARLOV. Ladies and gentlemen, I am Dr. Alvin Tarlov from the University of Chicago. I am also chairman of the Graduate Medical Education National Advisory Committee, referred to as GMENAC.

The report of GMENAC was submitted to the Secretary on September 30, 1980. Since then I personally have given dozens of addresses and interacted with dozens of groups on this subject, with medical societies, medical schools, training hospitals, State legislative and regulatory groups, college students, medical students, interns, residents, fellows, and others.

These experiences have helped me develop a comprehensive and deeper understanding of health manpower issues from the varying perspectives of government, health professionals, educators, students, patients, and the general public. I think I understand what the impact is likely to be of decreased government outlays for medical education and profession for health care through medicare and medicaid programs and further decreases for biomedical research.

In the time that I have available here, I would like to persuade you to continue Federal funding at the current level for the primary care grants for general internal medicine, general pediatrics, and family medicine.

The national objectives of providing equal access to high quality health services for all Americans at an affordable cost has achieved uniform consensus. Steady progress in the right direction has been accomplished by combining Government and private sector action. The goals—equal access, high quality, affordable costs—can be satisfactorily achieved.

But the system is complex. The parts are incredibly intertwined, and no single factor can be pointed to as being dominantly determinative.

Nevertheless, one common denominator, a recurrent and binding thread, is specialty distribution. Specialty distribution is the vector force which moves equal access, high quality, and affordable costs coordinately in the desired direction.

Through a variety of influences, during the 1950's and 1960's the distribution of specialists in the various medical fields became too heavily specialized and the number and percent of general physicians for primary care declined, to the detriment of national objectives. Over the past decade, through the coordinated efforts of the Government, the medical schools, the teaching hospitals, and the profession generally, this trend has been reversed.

Federal special project grants have played a key role. The new field of family medicine was spawned, with more than 2,300 graduating medical students entering family practice residency training last year. About 5,500 graduating medical students enter internal medicine training each year. In 1975, however, 75 or 80 percent of those trainees went on to subspecialty training, which although also important, cannot be considered totally as primary care fields.

Since 1975 this percentage has fallen by increments to 50 percent in the current year. More is yet to be done.

The major structural feature of these primary care training programs is their emphasis on outpatient training and service. Unfor-

unately, the reimbursement system does not permit underwriting the cost of ambulatory care training from ambulatory services. The financial incentives throughout the training program are toward hospital care. This is not likely to be remedied, this or even next year or the year after that.

Therefore, if the primary care grants are diminished, are discontinued, the present progress in primary care training will be arrested and will in all likelihood be reversed for financial reasons.

Not only will the numbers of trainees in primary care decline, but the substantial effect these programs have on the other training programs in the teaching setting will be diminished.

Further aggravating the situation will be declining medicare and medicaid support, which promise to place additional stress on the primary care training programs. Further, as the Nation heads toward a physician surplus, unpreventable for the 1990's, the desirable goal of encouraging the surplus into the primary care fields will be dampened.

For all of these reasons, ladies and gentlemen, and recognizing that you can only support some, not many, special projects, I suggest to you that we will get more and many times amplified effect in the desired directions of equal access, high quality, affordable cost, from continuing support of the federally sponsored primary care programs.

Thank you.

Mr. WAXMAN. Thank you very much.

For the purpose of the committee, could you just tell us what the purpose was of GMENAC when it was created, what it has accomplished, and then also what you expect for GMENAC in the future?

Last year we had it in our bill to make it a permanent and statutory organization. Do you think that is an advisable idea, and what would you see for the future of GMENAC?

Dr. TARLOV. In the congressional debates in 1976 on Public Law 484, the Congress asked for information as you are asking today, data related to information on the numbers of physicians needed in the United States. And their request for this information from the Department of Health, Education, and Welfare, the response from the Department was unsatisfactory to the Congress in that the body of knowledge on the numbers of doctors, their specialty distribution, their geographic distribution, and the financing of graduate medical education, were incomplete, if not unknown.

At the completion of the debates, the Speaker of the House wrote to then Secretary David Mathews requesting that the Secretary establish a mechanism for providing the Congress on a regular basis with the information that the Congress wanted. And Secretary Mathews then, in the last day of that administration, established by charter advisory to the Secretary a committee, largely from the private sector, but intended to be, and it was, a collaborative effort by Government and the private sector, this committee, to advise the Secretary on the numbers of doctors needed and appropriate specialty distribution of those doctors, ways to improve the geographic distribution of physicians, and fourth, a preferred method for financing graduate medical education.

The committee was then formed some time after that by Secretary Califano by appointment. The committee was recharted some

time after that by Secretary Harris. And the charter stipulated that the report be submitted by September 30, 1980, and it was.

Now the report did deal with this charge and is now available for your study. Essentially in terms of numbers, the report predicted from a determination of supply and requirements for physicians that we are headed toward a surplus of about 70,000 physicians by about 1990.

Now that prediction lacks credibility with some individuals unless one understands that at the present time, according to our figures, there is a shortage of physicians of about 5 or 6 percent.

Mr. WAXMAN. Dr. Tarlov, before you get into that important aside, I would like an answer more directed to the question. GMENAC has completed its job in filing this report. Is there any purpose you see in GMENAC for the future?

Dr. TARLOV. Well, I personally do. The committee itself voted unanimously to recommend that the work of the committee be continued for a variety of reasons, and the committee itself voted somewhat short of unanimity, but almost, that this be established by Federal legislative action by statute, and the reason for that was given their commitment that that kind of an activity should continue, the uncertainty of rechartering was such that the committee on balance felt that it ought to be statutorily permitted.

Mr. WAXMAN. What work would there be for such a committee if it was extended, since the report has already been filed?

Dr. TARLOV. Largely there is some unfinished work, but by and large, I think the collaborative effort between the Government and private sector worked effectively, and I think there are large manpower problems looming on the horizon that have important effects for medical education, and important meanings for legislators in terms of the bills that you are considering.

Medical education, graduate medical education, and geographic distribution of physicians, the cost of medical care, the problem of the structurally underserved, what do we do about health care in the inner cities; all of these things are intertwined and at their nexus is the manpower issue.

It would seem to me wise to continue a comprehensive and coordinated study of this problem held in public forum, and in making the data available for everyone.

Mr. WAXMAN. Dr. Gehringer, you have given us an outline of the maldistribution of specialties and why the primary care specialty is less than other specialties. How much of that is due to reimbursements to physicians as opposed to other causes?

Dr. GEHRINGER. I'm not sure of the question, Mr. Waxman.

Mr. WAXMAN. Students are deciding to go into specialties other than primary care. How much of that decision is based on the economics?

Dr. GEHRINGER. Not very much of it. I think the type of student who goes into family medicine is a rather unique student. He is very society oriented, he is very humanitarian and family oriented. We see him come in to medical school with a variety of other students fitting this mold, but somewhere along the way we lose a high percentage of them and wind up with a small percentage staying in family practice.

I have thoughts about why that happens also. I think we need to upgrade our students, that is to expose the students to role models. Most of the students decide what specialty they are going into by role model. They see a physician in medical school who provides a good role for them, they accept that. About 20 percent of them come into medical school, knowing exactly what they are going to do, and they are probably fortunate, but most of them make up their minds later, and I think role model is important, and I think we have to have family doctors in that academic setting for that purpose and other purposes as well.

Mr. WAXMAN. Why should we put Federal money into family practice?

Dr. GEHRINGER. I tried to point that out in my report. I think the reason is the family practice residency training generates very little income. We are dealing with ambulatory patients primarily. We get them in the hospital and out of the hospital in a hurry. Other specialties are dealing with technical, high-expense problems. They put them in the hospital, it's a big bill. The percentage of income for that type of service can afford to pay for their residency training. We can't.

In fact, we have shown you we can only generate 20 percent of what is needed for family practice programs.

Mr. WAXMAN. You are talking about income to the student or school?

Dr. GEHRINGER. To pay the faculty salary, the overhead for the clinic, to buy the supplies for the clinic, to hire the nurses and this sort of thing.

Mr. WAXMAN. Why wouldn't a medical school want to provide a family practice specialty or surgical specialty, or whatever might be needed? Why don't they take that as part of their expenses in running the institution?

Dr. GEHRINGER. I think some are trying to do that. We have asked them to pick up a mighty big tab here for family practice. This is an expensive training program.

Mr. WAXMAN. Aren't you in effect telling us that the schools receive money for services that are rendered, and the services rendered by family residents or family physicians is not reimbursed the same way as surgical services would be reimbursed? So the school's ability to handle that specialty is limited by the amount of money available?

Dr. GEHRINGER. What I am saying is if I have a surgical residency program over here, they are going to generate substantially more money by operating on people, by doing technical procedures than my residency program is going to do over here, providing preventive health care. You just don't get paid much for that sort of thing.

So if you separate out the amount of money I generate and say, "Dr. Gehringer, you support your residency program on what you generate," there is no way I can do it. If I did that, I would be running a service mill. I would not be training doctors. I would just be providing a service.

Mr. WAXMAN. The American Service of Family Physicians' goal is for 25 percent of physicians to be trained in family practice. About 15 percent are in family medicine. This number has not

increased. Why has this leveled off, and what would be necessary for you to achieve your 25-percent goal?

Dr. GEHRINGER. One reason is we are not getting enough exposure at the undergraduate level to role-model the students, to keep their interest up. We need to keep their interest up. And you are supporting that. You started this year supporting departments to improve, and I think that's a fantastic step. I can speak personally. I have got one of those grants on my desk, and it has helped immensely. We are going to have a 3-year mandatory clerkship in family medicine next year, and I think it is primarily due to the grant Congress was able to give us, or we were able to achieve.

I think the other reason is at the present time, we don't have enough good first-year slots. Now we've got 2,500, I believe, slots available in family practice, and they are 94 percent filled. They are not 100 percent filled, because some of them are not very good, just like any training program. Some of them are in geographic areas that are poor, unattractive to the resident.

But I think that by enlarging the good existing programs and searching out sites for other good programs that would fit the same mold, if we had some more good programs and good role-modeling at the undergraduate level, there is no doubt in my mind that that 25 percent will occur over the next several years.

Mr. WAXMAN. Mr. Benedict?

Mr. BENEDICT. Thank you, Mr. Chairman.

I think you all were here and heard Dr. Blendon's comment about the structurally underserved. Dr. Tarlov especially has testified to the fact that we are facing a physician surplus here in the future, and it doesn't seem that the programs we have in effect are going to touch that program. If Dr. Blendon's citing of Boston as a high ratio of physicians to population in the city of Boston—is there anything within this legislation we are considering today that helps to reach those people that are structurally underserved? Can either or both of you address that for me?

Dr. TARLOV. I think that problem is complicated, but I'll take a whack at it.

First of all, I think the specialty distribution is key because the more specialized the practitioner, the more likely that individual is to practice in a populated area with modern hospital facilities and other facilities, and not in the area of poverty that you have been addressing here.

So No. 1 is specialty distribution.

I think to maintain a high level of training in the generalist fields is key, and that is part of your bill.

Second, not in your bill, but at least as important, is the reimbursement system which provides incentives that were laudable in the beginning, but now have outrun their usefulness in my point of view, and provide incentives that are contrary to public policy objectives; such as the emphasis, the encouragement for hospital care as opposed to outpatient care. It's for technologically intensive services rather than time-intensive services, and indeed the usual customary favor is the establishment of a practice in an area in which the reimbursement rates are higher, and these three things aggravate the problem, so I would say specialty distribution is No. 1; and No. 2 is some modification of the reimbursement system

which would put the incentive where the policy objective is and get you the doctors in those areas, in my opinion.

But I would caution that the problem is not strictly a medical one. These areas suffer from a lot of distributive problems in terms of housing, welfare services, city services, educational services, clothing, food, and other things.

It is not a simple problem, and a doctor establishing a practice in those areas considers a lot of things. Those that we have just mentioned. Also safety, the availability of other medical resources close at hand, et cetera.

Mr. BENEDICT. Dr. Gehringer.

Dr. GEHRINGER. I would like to add one little tidbit that our Committee on Minority Affairs is at the present time planning an indepth look in developing a pilot program of family physicians in one of these areas, mainly to again role-model to the young doctor that it can be done, and how it can be done. You've got to get in there and show these young people that this is possible. Without that, it will never happen. So this is our start. We are going to try.

I think a lot of people who have fallen into this group of the underserved are probably in the older age group as well, and at the academy we have found family physicians probably take care of about 42 percent of the old people in this country to date, and we want to enlarge on that.

We have undertaken some very realistic projects recently. We are developing workshops for a curriculum for a family practice residency and problems of the aged, and this will be mandatory.

In the past I did a survey that showed only about 67 percent of our residency programs were structurally dealing with this problem, but now we want all of them to do it.

We are also developing regional workshops to teach teachers how to teach problems of the aging, because we don't have a good corps of teachers of problems of the aging.

We are also developing workshops to continue education for our practicing doctors on problems of the aging. A high percentage of our elderly are in rural America, and I think from the data I presented to you today that a high percentage of our people are going into communities under 25,000. If they are well trained to serve this population, I really think we are making some steps in the right direction.

Mr. BENEDICT. My objection is I'm not so much interested in educating physicians as in providing medical care where it's needed, and I'm not too willing to have the taxpayers spend money for people in those areas where they can take care of themselves. There are all kinds of factors involved here, perhaps, more than education. Educating physicians is not going to cure this problem. There are societal problems, basic structural problems in our society, and we are really missing the point in talking about this bill.

Dr. TARLOV. Not necessarily. I mean there is more to it than is in that bill. I would agree with that. But, for example, in that bill also, you touch on student loans, and assistance programs, to assure higher enrollment of minority students.

For example, as I get it, the drift of your concerns, the minority education problem is a serious one, and it's going to become even more serious. In the late 1960's and the early part of the 1970's, the

enrollment—let's just take one minority group, the blacks—in-creased in the first year class up to about 6 percent of the total.

Now what do we have? We have 11.7 percent of the population black, and we have 5.5 percent of the graduates black and 3 percent of the physicians currently are black, and when you look at the practices of black physicians, 80 percent of their patients in fact are black, and if you look at the practices of white physicians, 7 or 8 percent of their practice is black. If you look at where blacks receive their medical care in the private sector, 80 percent of it is with black physicians.

I don't know whether that's going to change or not, but unless we modify the system of attraction for black students to enter medical school, then you are going to be stuck with about 800 black graduates a year with 5 percent of the national physician population being black. That is not going to change, and the reason for that is that with decreasing loans and scholarships for medical students, with medical schools having to receive more and more of their revenue from tuition, tuition rising to \$9,000 or \$16,000, in some schools, medicine is becoming less attractive as a profession, especially to the minority students.

They have told me repeatedly that they can make it bigger and quicker without the indebtedness in law, engineering, and in business. And it seems to me that is a problem that is addressed in this document here, and that we ought to pay a lot of attention to.

Mr. BENEDICT. Thank you.

Mr. WAXMAN. Ms. Mikulski.

Ms. MIKULSKI. Thank you, Mr. Chairman.

Dr. Tarlov, I have some questions for you. Can you explain to me why GMENAC's report recommended that funds for nursing training be cut in light of the fact that all reports indicate we need better trained nurses and most States are facing severe nursing shortages? My own being one.

Dr. TARLOV. The GMENAC report did not deal with that subject. In fact, there is nothing in the report that calls for a decreased support for nurse training.

Ms. MIKULSKI. Didn't you talk about freezing current training levels for nurse practitioners and assistants and midwives?

Dr. TARLOV. Yes, we recommended the current level of training be maintained. Now, the current level of training is one that will assure an increase in the numbers of nurse practitioners, assistants, and midwives from the present number in 1978 of approximately 20,000 to a level of 50,000 in 1990.

GMENAC recommended that that level of training be maintained.

Ms. MIKULSKI. Why? And why not increased?

Dr. TARLOV. Because we recommended that manpower studies now proceed beyond medicine and include the other professions; nursing, including the three that you have indicated, or the two you have indicated; podiatry, chiropractic, optometry, and the other fields. Because it would seem that with an impending physician surplus, it would seem unwise to increase the training of these other professionals out of the context of some comprehensive coordinated manpower program.

Ms. MIKULSKI. But aren't these exactly the type of other health professionals that then work in the health clinics and rural delivery systems where there is an underserved population?

Dr. TARLOV. Yes, some of them would, and I would address Mr. Benedict's questions that over the short term that represents some hope for improving the care in the areas of your concern.

Ms. MIKULSKI. What about long term?

Dr. TARLOV. In the long term, it seems to me there needs to be a national consensus on the delivery of health care as to whether the primary care services are going to be provided by the generalist physicians on the one hand, on the one extreme; or by nonphysicians on the other extreme, that is nurse practitioners, physicians' assistants, midwives, et cetera; or by some combination of the two.

The alliance between the nonphysician and the physician in the delivery of health care is rather tenuous at the present time, outside of the field of nurse midwifery, where it seems to me that it is rather well established and works effectively. In that field GMENAC did recommend that the number of births handled by nurse midwives be increased from its present level of 1 percent to a number level of 5 percent by 1990.

We felt that the rate of training of nurse midwives could accommodate to a fivefold increase in births by then in that period of time.

Ms. MIKULSKI. The reason I asked is because I think we are looking at combinations and how best to develop a national policy of delivering services. In testimony we have heard in previous Congresses, one of the things that emerged is that the solo practitioner working in a demanding, tough area—whether it be an inner city area or on the frontiers of a rural community—is so personally exhausted that, they really burn out in a very short period of time. But where there is a combination, where a physician is backed up by other personnel—a physician's assistant, a social worker to deal with some of those economic issues that the gentleman from West Virginia raised—you maximize your physician, and you also aid in the maximizing and more efficient use of the physician's particular skills. This also leads to a more satisfactory work environment and facilitates the retention of those physicians.

That's what I'm trying to look at. You might have a whole surplus of docs generally, but if you cut short other professionals, we might be hurting a lot of people.

Am I on target with this?

Dr. TARLOV. Oh, absolutely. I agree 100 percent. What I am suggesting to the committee, however, is that we not repeat the errors of the late 1960's, when we understood that we needed more doctors, but we didn't know how many more, and we increased the entering class two and a half fold, and now 12 years later, we are aware that we are going to be oversupplied.

I would suggest, therefore, that we understand that although there are 20,000 nurse practitioners, physician's assistants and nurse midwives at the present time, we are going to have 50,000 in 1990, that we ought not to change the rate of training until the manpower study is done, so that we know how many we are going

to have, and whether we are going to be oversupplied or undersupplied. That's all that CMENAC said on that subject.

Ms. MIKULSKI. Thank you.

Mr. WAXMAN. Mr. Whittaker?

Mr. WHITTAKER. Thank you, Mr. Chairman.

Dr. Gehringer, on page 4 of your statement, you state:

If federal funds are significantly reduced, the supply of new family doctors entering the system will not only remain the same but may decrease dramatically.

My question is, does this mean in your opinion that primary care physician training programs cannot maintain their balance, in spite of the seed moneys the Federal Government has provided?

Dr. GEHRINGER. I think the answer to that is yes; I don't think it can maintain.

Mr. WHITTAKER. Then in lieu of your response, how long do you believe the Federal Government will have to remain involved?

Dr. GEHRINGER. We would like to think the States would be ready to step in and pick up their share of it, and in many States, this has happened.

However, a lot of these programs are in community hospitals outside of State support, and they have to rely on the income they generate from the practice setting. It just isn't enough, and that's the point I was trying to make.

If this is a real issue, and I think it is—I think Mr. Benedict kind of got me on this a minute ago—but I think there is some societal responsibility to train this type of physician.

I think what we have done with the seed money you have given us so far is we have proven the concept is realistic, workable and necessary, if we are going to provide good health care for all of our citizens. And I am saying that perhaps we will have to be involved in it for some time.

Mr. WHITTAKER. Doctor, for my edification and possibly the committee's, would you share with us what percentage of the residency programs are returned in fees for the specialty of surgery?

Dr. GEHRINGER. I have no idea.

Mr. WHITTAKER. How about GYN/OB?

Dr. GEHRINGER. I really don't have those figures.

Mr. WHITTAKER. But you considered it significant to relate that family practice is only 20 percent. I would like to have a comparison.

Dr. GEHRINGER. I don't have it. I'll get it for you.

Mr. WHITTAKER. Mr. Chairman, may I request that the record remain open?

Dr. GEHRINGER. I will send them to you.

[The material requested was not available to the subcommittee at the time of printing.]

Dr. TARLOV. I think that maybe the concept that you are asking for here needs some clarification because—we are talking—are we talking about graduate residency training? The cost of graduate medical training, by and large, is from hospital fees paid for in-hospital services and not from professional fees paid to the doctor. So that the cost of graduate medical education, the direct cost, is about \$1 billion a year, paid through hospital revenues.

Now the problem with that is that when you get a specialty like family practice or the primary care programs in general medicine

and pediatrics, where their focus is outside of the hospital and ambulatory, there is no such agreement on the part of the payers of ambulatory care that the cost of training should be included in the cost of ambulatory care, as there is on in-hospital care.

Mr. WHITTAKER. I appreciate what you're saying, and I do understand your logic, but I think it would be informative for the committee if you could try, through a subjective analysis, to at least apprise us of what sort of support through revenue the program may then receive.

Dr. TARLOV. That's easy. The programs you asked, in surgery, and in OB/GYN, ophthalmology, I would say that those programs, except for special project grants, 80 to 85 percent of the cost of those programs is borne through patient revenues from hospitalized patients.

The rest of the costs are from other sources, grants and contracts and special contract grants.

Now if one looks, then, at the three fields that I indicated where the dominant education transaction is in the ambulatory arena, only about 20 percent of the cost of those programs is borne through patient revenues. The other 80 percent has to be found some place else.

And I am suggesting to you, Mr. Whittaker, that if you withdraw your support from those programs in terms of the special project grants, that it will have one immediate effect and another long-term one:

The immediate effect is that it will drive those training programs to the hospital where they can get the programs funded.

The second effect will be a decrease in the number of trainees in these programs which will follow later on as the hospitals become increasingly aware that they are just not going to be able to fund those programs.

Mr. WHITTAKER. Thank you.

Dr. Gehringer, I really considered revealing and informative your reference of role models, because in my conversation with quite a number of medical students, they indicate to me that this is in principle very much true.

However, is it not still the case in many of our institutions that frequently the staff on our medical schools and residency programs are, by their own specialties, specialists? And in many cases will belittle the primary care physician?

Dr. GEHRINGER. That's very true.

Mr. WHITTAKER. What can we do to alleviate that situation?

Dr. GEHRINGER. I think you have to have, number one, enough family practice faculty to be in there shoulder to shoulder, and we need to be available. We need to be seen. We need to be there, we need to make rounds on those other services with the other specialists and contribute the role of the family physician.

Now, to me, that's the way you do it, and that's been very successful for me. But you have got to have enough faculty.

Mr. WHITTAKER. It's pretty hard to change impressions.

Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Shelby.

Mr. SHELBY. Thank you.

I would like to ask the Chair something first: Has the General

Accounting Office done any work in this area on this particular cost outlay?

Mr. BILES. Yes; they had extensive reviews of the whole question of special distribution of physicians in 1977-78.

Mr. SHELBY. Has it been updated?

Mr. BILES. I don't know that it's been updated since then, but it was a fairly definitive work at the time, and we could certainly make that available.

Mr. SHELBY. I'd like to see that. I think that would have some probative value in what we are doing here.

Mr. Chairman, I would like to ask the gentleman from Louisiana a question. I'm glad you got out of New Orleans, and Mardi Gras is over and you got up here.

In Alabama, particularly in my area of the Deep South, and some of the other areas you are familiar with, I am sure, we have had a tremendous shortage of family-type physicians, and we started out 10 years ago, like a lot of rural areas did, in trying to supply it. We had some counties with no doctors, and now we are beginning to get doctors in there, and I have to believe it's because of this program; at least part of it. You can't attribute everything to it.

I would like to know who is doing these manpower studies, the models for them, on where the physicians are going in different areas, and if there are any updates on them, why and so forth.

Dr. GEHRINGER. Well, the American Academy of Family Physicians Research Committee has done some surveys on our graduates.

Mr. SHELBY. Did they contract that out?

Dr. GEHRINGER. No; we do it ourselves, and we have done studies on our graduates and on this particular question, 6 percent of the graduates were practicing in primary care health manpower shortage counties. If the whole county is designated as a HMPSA then 6 percent of our graduates are in that type of location. Forty-seven percent are practicing in wholly or partially declared primary care shortage counties.

So 6 percent are in counties that are absolutely totally without primary care, and 47 percent are in counties that may have some of both. I can't be sure in that group whether they are in the city area or out where the shortage is.

The States have done some studies. I have done a study in Louisiana on our graduates to see what's happening to them, and it pretty well follows the trend that the national study shows. Most of them have gone into small communities; 90 percent of them have stayed in Louisiana. That's what's beautiful.

Some of them are in metropolitan areas, and that's great, too, because the biggest shortage area in Louisiana today for family doctors is New Orleans. Not probably, it is.

Mr. SHELBY. Because of the inner city?

Dr. GEHRINGER. For one thing. And another reason is that was the last residency we developed for family practice was in New Orleans. It's only 2 years old. I think if it holds true to the programs we developed in Lake Charles and Baton Rouge, we have seen substantial numbers of residents who stayed in those areas.

Now they have not answered the question of the deep, hard-core-poor sections of the city. No, we haven't answered that question, but we are trying to.

Mr. SHELBY. But you heard the gentleman on the panel earlier talking about Boston and Charleston and other areas. Wouldn't it probably logically follow—and I know you don't know, you haven't had time to do it, as you just said—but if you staffed these areas with family resident-type programs, wouldn't some of them naturally—minorities and otherwise—tend to stay in an area that you are used to, that you get to like, and so forth?

Dr. GEHRINGER. We believe that's true, and that's why we are going to try to develop this pilot type program in this type of area. Developing a residency training program in that area is a little different. It's a little more difficult to do. You even have patient resistance.

I tried to develop one in a central city area of New Orleans where Charity Hospital had one of its outreach clinics, and there was resentment from the patients. They weren't sure what this was, and they weren't sure they wanted to change the pattern they already had. And I might relate to you personal experiences. When medicare and medicaid first came out and I was practicing in rural Louisiana, I would tell the patient, "Why do you go all the way to New Orleans to Charity Hospital? You've got medicaid. You can be seen right here."

"I know, Doc, but I'm afraid if I don't go and my name gets off that list, I can't get back in if I have to."

So there are so many factors involved in this. We are looking at it, believe me. I don't have the answers. No one else does.

Mr. SHELBY. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Dannemeyer.

Mr. DANNEMEYER. Thank you.

Dr. Tarlov, I'll go back to this point I mentioned earlier. The distinguished chairman has suggested that we run this program to the tune of some \$2.845 billion and the administration, on the other hand, has recommended we can fill this need with \$1.111 billion.

Considering that we expect to have a surplus of 70,000 doctors by 1990, do you still believe we should fund it at the level suggested by our distinguished chairman?

Dr. TARLOV. Yes.

Mr. DANNEMEYER. You do?

Dr. TARLOV. Yes.

Mr. DANNEMEYER. Considering that the majority of the people in this country pay the taxes and are demanding that the Government get its fiscal house in order and reduce spending; considering that as given, do you think it desirable for Congress to reduce spending so as to reduce inflation in this country?

Dr. TARLOV. Yes.

Mr. DANNEMEYER. And do you have suggestions as to which programs we should cut in order to bring the spending to come into balance with the income?

Dr. TARLOV. No.

Mr. DANNEMEYER. You are suggesting, I guess, that we cut somebody else's program, but not this one?

Dr. TARLOV. No; I am suggesting that we continue to place a high priority on health as a fundamental and important value in America. And I am suggesting to you that you are not going to be able to do that with a \$1.1 billion appropriation. Something is going to suffer from that.

Mr. DANNEMEYER. Do you think those in the administration that are suggesting we can fulfill this responsibility by spending \$1.111 billion lack judgment?

Dr. TARLOV. No.

Mr. DANNEMEYER. Do you think they are any less sincere about promoting the objectives that you seek?

Dr. TARLOV. No.

Mr. DANNEMEYER. Then what you are really saying, I think, sir, if I may use this phrase, is that, whether you want to come right out and say it or not, you want inflation perhaps to be reduced, but you don't want to cut this spending program because, in your perception, the health care needs of this country should take precedence over the necessity of reducing spending and bringing inflation under control. Is that what you are saying?

Dr. TARLOV. No. I mean that's what you said I said.

But that's not the way I would phrase it. I understand that your job is difficult. I am also trying to persuade you that health care, health education and better health for the people is a very complicated subject, and that there are many intersecting parts of which health profession education is one part.

The medicare and medicaid entitlement programs are another part.

Equally important are other social programs related to transportation, to food, to housing, and other things. It's a very complicated subject, and I am suggesting to you that in my own system of values, with a Federal budget on the order of \$6 or \$100 billion or more, that expenditures on the order of \$1 billion, for example, for graduate medical education, are not extraordinary as an investment in the Nation's resources and health. And I am indicating to you that over \$2 billion for health profession education, considering the national expenditure for health, and considering the value that the American people place on health, is not extraordinary in my judgment.

I do, however, recognize that it is a judgment on my part. It's a judgment call. It's an opinion.

Mr. DANNEMEYER. Well, you speak to the physical needs of the people that will be met by the medical practitioners trained thanks to these expenditures. That is a laudable public goal.

Let me suggest, perhaps, that you are overlooking, in the process, the effect on the emotional and mental stability of a population base which fears that its currency is being debased year after year by excessive Federal spending. There are a lot of people in this country who have that gnawing fear; the fear that the system is close to, if not out of, control, and they are as much concerned about bringing that spending under control as they are about providing adequate health care for the people of this country.

Dr. TARLOV. I agree.

Mr. WAXMAN. Thank you, Mr. Dannemeyer.

Dr. Tarlov, Dr. Gehringer, we appreciate your being with us, and I'm sure we will find the testimony you have given very helpful.

I next would like to call forward two representatives from the national American nursing organizations, Connie Holleran, Deputy Director of Government Relations, American Nursing Association, and Sally Austen Tom, Government liaison of American College of Nurse Midwives.

I would like to welcome you both to today's hearing, and we will pay special notice of Ms. Holleran's presence with us which may be the last time for you to appear before the Congress. So let me pay tribute to the fantastic job you have done, I believe, for 10 years coming before the Congress and giving us the benefit of your expertise and guidance in drafting legislation affecting the nursing profession.

For the members of the subcommittee, who may not be aware of this fact, Ms. Holleran will be going to Geneva working in the area of international medicine. It will be a loss for us, but a gain for international medicine.

STATEMENTS OF CONNIE HOLLERAN, R.N., DEPUTY DIRECTOR OF GOVERNMENT RELATIONS, AMERICAN NURSES' ASSOCIATION; AND SALLY AUSTEN TOM, GOVERNMENT LIAISON, AMERICAN COLLEGE OF NURSE-MIDWIVES, ACCOMPANIED BY MARY COPELAND, NATIONAL STUDENT NURSES ASSOCIATION; HELEN GRACE, NATIONAL LEAGUE FOR NURSING; AND SISTER ROSEMARY DONLEY, AMERICAN ASSOCIATION OF COLLEGES OF NURSING

Ms. HOLLERAN. Thank you.

The nursing groups have agreed to have me as the major spokesperson in the interest of time. Representatives of the American Association of Colleges of Nursing, the National League for Nursing, and the National Student Nurses Association will be available for questions and are here at the table as well.

We recognize that this committee developed a very thorough hearing record on the issues of nurse training late last year. The deadlock on conference issues was unrelated to those of nursing, and H.R. 7203 passed the House by a vote of 368 to 8.

The situation in nursing has not changed since 1980. In fact, the Office of Management and Budget now does acknowledge that there is a persistent nursing shortage. One hears various weak arguments that the increase in nurse supply that has occurred since 1965 is not related to Federal support programs.

We feel that the facts prove otherwise, and there is a direct relationship between institutional and student support, and that increased enrollment.

In 1966, 613,000 registered nurses were in the work force, and 135,000 were enrolled in schools of nursing. Today there are more than 1 million registered nurses in practice, and 236,000 students enrolled in schools.

The legislation has been altered considerably over the past 15 years, reflecting varying public and congressional concerns. The record shows that nursing schools have been very responsive to those changing priorities, and have worked hard to establish the special programs requested by the Congress.

Emphasis on primary care preparations, increased opportunities for low income disadvantaged students to become nurses, State and regional planning grants, establishment of new schools in areas of great need for nursing, preparation of faculty and nursing service leaders and preparation of nurses for practice in long-term care facilities, have all evolved as a result of these national Federal programs.

The funding has always been tight. In the last 4 years funding has declined in fact as well as a result of inflation.

You have heard earlier the results of a poll of nursing students which indicated that 51 percent received financial aid and 13.2 percent have Nurse Training Act scholarships and loans.

The loan forgiveness segment of these specialized loans is a very important factor in that program's success. Raising the limit on those loans is important to reflect increases in tuition and living costs.

Nurse practitioner programs were established as a result of congressional urging, not to compete with the physicians, but to provide high quality primary health care to those in need at reasonable cost.

Patient satisfaction and quality control reviews indicate that they are in fact providing this quality service.

Traineeships for graduate students have not kept pace with increased cost of students. Therefore, currently schools are allocating traineeship funds, tuition only, or partial tuition in some cases.

Stipends are not covered, although they should be a part of the program.

The ANA nursing inventory of 1978 shows that 75 percent of all registered nurses are in fact employed in nursing today.

In 1962, only 63 percent were actually practicing. When you take into account the retired and the ill who retain their licenses, and those who drop out for up to an average of 5 years while having families, the slippage is much less than some would have you believe.

Nurse frustrations are great in many health care settings. Understaffing, misutilization, and poor pay are all important factors. Yet there also has been a tremendous increase in the demand for registered nurses. Medicare, medicaid, medical research, utilization review, and an aging population are all factors that impinge on the nurse supply issue.

One cannot do straight population to R.N. ratios, because they just do not hold up.

We ask the committee to add a section to this bill, or to add an option to the project grant section to allow for some clinical demonstration units. The need to better utilize nursing skills has been acknowledged by many, but very little has been done to study how to improve that misutilization, or to directly relate nursing unit needs to educational programs.

Such an addition will focus attention on this urgent set of problems and will help to develop some solutions quickly.

We also ask that the committee separate out the nursing title into a separate bill to speed up its enactment, as there is almost panic among nursing students as they face again another year of uncertainty.

We do support H.R. 2004 and urge its prompt enactment.
Thank you.

[Testimony resumes on p. 182.]

[Ms. Halleran's prepared statement follows:]

AMERICAN NURSES' ASSOCIATION

by

Connie Holleran, R.N.

Director, Washington Office

Mr. Chairman, the American Nurses' Association is pleased to offer testimony on H.R. 2004, presently before this committee. We applaud your attempt to expedite this significant piece of legislation and appreciate your thoughtful consideration of our comments.

Nurses support the federal government's intention to control costs. We recognize that well-developed cost containment strategies must be implemented in all sectors in order to revitalize a struggling economy. The American Nurses' Association has supported voluntary health care cost containment, and we will continue to cooperate in efforts to assess current and future needs for the services of nurses and to plan to provide those services in a cost effective manner.

We believe that underutilization or misutilization of registered nurses is one contributing factor both in the current nursing shortage and in the continued escalation in health care costs. To help improve this situation, federal aid to nursing education has been essential both in helping to maintain an adequate supply of nurses, but also in supporting opportunity for the preparation of larger numbers of nurses to assume the increasingly complex responsibilities with which they are faced.

The legislation has been altered considerably over the past 15 years reflecting varying public and Congressional concerns. The record shows that nursing schools have been very responsive to those changing priorities and have worked hard to establish the special programs requested by the Congress.

Emphasis on primary care preparation, increased opportunities for low income and disadvantaged students, state and regional planning grants, establishment of new schools in areas of great need for nursing, preparation of faculty and

nursing service leaders and preparation of nurses to practice in long-term care have all evolved as a result of these federal programs. The funding has always been tight and the last 4 years funding has declined in fact as well as a result of inflation.

Today there is renewed media and public focus on a shortage of nurses. Health care providers are spending large sums of money to attract and recruit qualified nurses.

Predictions vs. Reality

The current concern about a shortage of nurses is of particular interest in light of projections made as recently as 1979, in an HEW report to Congress:

"Assuming even moderate changes occur in the health care delivery system, the overall supply of registered nurses will be in balance with requirements over the next decade. Shortages might occur if a national health insurance plan which significantly increases utilization were enacted and/or the utilization and responsibilities were increased substantially. However, significant increases in utilization are highly unlikely in the face of current and future cost containment efforts."¹

The fact is that the nature and scope of demands for nursing services have changed dramatically in recent years. And so, although between 1958 and 1980 the number of active nurses has more than tripled, and the ratio of active nurses to 100,000 population nearly doubled, and employment rates among nurses are 15 percent higher, -- in spite of all these signs of increased supply, we are faced today with what is being termed an acute nursing shortage.²

The American Nurses' Association has identified five major factors contributing to this situation: (1) increased demand for nursing services, (2) inadequate supply of registered nurses educated at the appropriate levels, (3) current vacancies in nursing positions (especially within the hospital setting), (4) misutilization of existing nursing manpower, and (5) growing discontent among nurses over multiple factors affecting their work environment. These factors are not mutually exclusive. The demand for nurses and nursing services is a complex issue

that involves not only the number of registered nurses in the work force, but also the quality of nursing services being provided to the public.

Demand for Nursing Services

The health care needs of today's society have triggered a greater reliance on nursing services. Alterations in population characteristics, scientific and technological advances, changing disease patterns, and diverse lifestyles have resulted in demand for a type of health care that was virtually nonexistent a decade ago.

Institutional Demand

The most significant increase in demand for nurses has occurred within the hospital setting. With the emphasis on removal of financial barriers to health care during the 1960's, hospital utilization increased. As a result of the enactment of the Hill-Burton Act, many hospitals were enlarged and more medical facilities were built. The addition of more hospital beds signaled the need for more nurses.

Moreover, the nature and scope of demands for nursing services in the hospital have changed. Today, hospitals are described as "RN intensive" because patient stays are shorter and thus a higher percentage of patients more critically ill requiring more continuous, comprehensive and technologically complex nursing care. In recent years, the number of beds in recovery rooms, intensive care units, and other highly specialized facilities have expanded dramatically when compared with the number of beds in general care units. In 1972, the nation had approximately 28,964 beds in intensive care units; by 1978, there were 41, 115. Beds in other specialized areas, such as open-heart surgical facilities and cardiac intensive care units, have also increased. Short stay beds accounted for 88 percent of all hospital beds in 1977 compared with about 69 percent in 1972, indicating a

higher turnover rate in the patient population. Between 1972 and 1977 surgery utilization increased more for persons 65 years of age and over than for those in any other age group.³

The number of long-term care facilities has multiplied as the demand for health care services by the elderly population has increased. The demand is expected to continue in the future as life expectancy increases. The number of nursing home residents during 1973-74 was 1,075,800. By 1977, this figure had risen by 21 percent to 1,303,100. This increase can be attributed, in part, to the growing proportion of persons 85 years of age and over.⁴ In addition, long-term care has expanded to include both institutional and non-institutional health care services.

Demand for Community Based Services

The hospital is only one of many settings for health care delivery. Nurses are the primary care givers in a variety of settings as the demand for community-based services grows. Working out of storefront clinics, nurses are now providing comprehensive health assessment for multilingual populations. They are offering services to the elderly in federal low-income housing, coordinating the home care of cancer patients and working in sexual assault clinics. Their services are used in correctional institutions, and are contracted for by state, federal and international health agencies. They are employed in rural health clinics, birthing centers, hospices, industrial clinics, convalescent centers, and schools.

Demand for Nursing Education

The increased demand for nursing services in all settings has heightened both the emotional and physical demands on registered nurses and the need for better prepared registered nurses. Educational preparation has a direct bearing on the nurse's ability to provide the type and quality of care that meets the needs

of the public.

Unfortunately, the most significant shortcoming of the nursing education system has been its slowness to adapt to changes in health care delivery. The need for nurses prepared at the baccalaureate and higher degree levels warrants greater attention. In 1977-78, more than 71 percent of registered nurses were diploma graduates, while only 23.5 percent of the nurses had baccalaureate or higher degrees.⁵ Projected requirements for nurses with at least a baccalaureate in nursing surpass the anticipated supply of such nurses, while requirements for nurses at the associate degree or diploma level are below the current as well as the anticipated supply. The American Nurses' Association believes that to adequately meet patient care needs there should be at least one baccalaureate prepared registered nurse available for every two prepared at the A.D. or diploma levels. It should be noted that there is no documented evidence to support the popular assumption that better educationally prepared nurses will increase health care costs. To the contrary, it has been shown that implementing an all R.N. staff can result in cost savings.⁶ It also has been demonstrated that managerial effectiveness is increased with fewer categories of better prepared personnel who can be held accountable for a broader range of patient care tasks.

Need for Leadership

Numerous reports reveal a severe shortage of nursing personnel prepared to fill leadership and functional roles such as clinical nurse specialists, nurse educators, nurse researchers, and administrators for service agencies and for education, government, and organizational work.

Clinicians

Clinical specialists for intensive care units such as renal, coronary care, and trauma care are necessary. Directors of nursing services report a serious

scarcity of highly skilled registered nurses, especially those prepared to care for critically ill persons. We believe that one master's prepared clinical nurse specialist should be available for every 8-10 experienced registered nurses.

Educators

In order to strengthen nursing education programs to meet demands for better educationally prepared nurses, more nursing educators are needed. In January 1978, a total of 20,217 full-time and 4,457 part-time nurse faculty members were employed in 1,358 R.N. education programs. There were 800 unfilled budgeted positions, 24 more than reported in January 1976. Of all the full-time nurse faculty reported as employed in R.N. programs, only 5.3 percent held the doctorate, and 62.5 percent the master's degree.⁷

Researchers

Many more nurses with advanced preparation are needed to address the complex problems concerning quality and delivery of care. In times of cost containment, innovations are needed. But innovations must be tested scientifically, which requires more nurses educated at the doctoral level to design instruments and methodologies suited to nursing phenomena. Equally important, more nurses must be prepared to interpret and apply these and other research findings in the practice setting.

Administrators

Nearly half (48.1 percent) of nursing service administrators do not hold even a baccalaureate. Yet nursing service administrators assume responsibility for 40-60 percent of a hospital's budget and 33-50 percent of its personnel. Only advanced education can prepare nurses to provide leadership in responsible fiscal management, in development of standards and quality assurance programs, in application of patient classification systems, in use of computers to project plans and predict consequences,

in development of research in practice and operations, and in promotion of exemplary learning opportunities for staff and students. At least one nursing service administrator with a minimum of a master's degree is necessary for every hospital, long-term care facility, hospital or nursing corporation, supplemental nursing service, and health maintenance organization in the health care system.

Need for Doctoral Preparation

According to preliminary findings from the 1979 National Survey of Nurses with Doctorates conducted by ANA and funded through the Division of Nursing, Health Resources Administration, there are approximately 2,500 nurses with doctorates in the United States.

The data suggest an acute shortage of nurses prepared at the doctoral level to meet the needs of educational and service settings. Nearly double the number of nurses with doctorates are necessary today to meet the needs of nursing education programs alone. Almost triple the number is necessary to begin to have an effect on the education and service needs of nursing.

New Nurse Training Proposal

We are pleased that H.R. 2004 would extend the Nurse Training Act for three years. Lack of consistent policy direction during the past few years has severely affected program planning in schools of nursing. Continuity will in addition enhance and provide a broader base for evaluation of program effectiveness.

It is our opinion that use of the term Nurse Education Amendments more appropriately projects the present preparation of nurses, and we would urge adoption of this terminology.

Sec. 821: Advanced Nurse Training

As has been noted, there is a severe shortage of nurses prepared at advanced

levels for clinical and functional roles such as teachers, educational and service administrators, and researchers. It is therefore ANA's priority that these programs continue to be funded. Evidence has been provided regarding the acuity of patients in the health care system and the demand for nurses educated to meet these needs. Programs at the higher degree level must be strengthened to encourage flexibility and innovative approaches to learning, such as weekend, part-time, satellite, and out-reach programs.

In 1978-79, a total of 4,621 students graduated from 127 master's programs in the United States. Twenty-five doctoral programs graduated 101 students. These figures represent only a small percentage of the nurses needed to provide cost-effective quality care in today's health care system.

Sec. 820: Special Projects

This program has fostered the development of new nursing methods emphasizing primary care, health education, prevention and greater cost effectiveness. Emerging and innovative organizational patterns that bring together health care resources in a unique and comprehensive manner must be encouraged.

We urge continuation of Special Project Grants with the inclusion of demonstration projects in a variety of clinical settings---large teaching hospitals, smaller hospitals, home health settings--using faculty and students in new, cost-effective methods of providing nursing care. Such projects can contribute greatly to improving the delivery of nursing care. They can provide new approaches to both nursing education and nursing service and give students first-hand experience in providing high quality nursing care.

Sec. 822: Nurse Practitioner Programs

The American Nurses' Association urges that all nurse practitioner programs

be at the graduate level in schools of nursing. We recognize the unique role that continuing education has demonstrated in the past, but we are aware of the current demand for nurse practitioners prepared to function independently in a variety of settings.

Studies are beginning to demonstrate the cost effectiveness of the nurse practitioner in the health care system especially in providing quality care to traditionally under-served groups. Nurse practitioners provide a broad array of services and can greatly enhance the quality of health care.

The American Nurses' Association does not view the nurse practitioner as a substitute for the physician. Rather, we believe that the nurse practitioner is most effectively used to extend health care services to more completely meet the needs of the population.

Sec. 830 : Traineeships

Although enrollments in master's programs rose by nearly 8 percent in 1979 over the previous year, the population of full-time enrollees dipped below 50 percent. It is predicted that with the increase in part-time enrollments, slowdowns in growth rates of graduations will occur.

Further, in light of recent inflation and economic concerns and increased numbers of persons entering nursing as a second career, we believe that traineeships must be maintained. Due to the high demand for better prepared nurses, we would additionally urge consideration of offering some assistance to part-time students possibly tied to accelerated pay back systems.

Sec. 835-846: Loans and Scholarships

Nursing remains one of the lowest paid professions in the country, and many nursing students come from homes with incomes that are not high enough to support any post-high school education. A survey by the National Student Nurses Associa-

tion showed over 50 per cent of nursing student respondents coming from homes with incomes below \$15,000 per year. The request for loans and scholarships consistently outstrips funds available. The NSNA survey reported that 85 per cent of students receiving federal funds said they would be unable to continue their education without that assistance. A total of 61.33 per cent of the students responding to the NSNA survey said that they held jobs to help meet education and maintenance costs.

The nursing student loans and scholarships are designed particularly for disadvantaged and financially distressed students, and they are especially important for minority students.

We believe it is essential that this study assistance be continued.

We support loan forgiveness as a mechanism to relieve maldistribution and improve access to care.

Sec. 810: Institutional Support

Despite the fact that the total number of basic R.N. programs increased slightly during 1978-79 and 1979-80, the total number of admissions decreased for the third year in a row. In addition, for the first time, the basic R.N. graduation rate declined in 1978-79, and a further decline is predicted for 1979-80. There is a concern that these declines will continue given the additional facts of the swollen pool of high school graduates and the new fields that are opening up to women.

It is not only to number, however, that funding must be geared. Better prepared nurses are needed to meet current demands. Programs must be able to provide opportunities to those desiring to enter the profession as well as those desiring to continue career development.

Opportunities for access to quality nursing education for all students should continue to receive priority attention, with emphasis on recruitment,

retention, and graduation. We urge that schools demonstrating innovative programs in nursing education - such as outreach, models of faculty practice, strategies for collaboration of nursing education and services, and approaches to contributions in health care delivery systems - receive funds. Support to programs such as these will encourage flexibility within nursing education.

Sec. 801: Construction

In order to facilitate flexibility in nursing education programs, resources should be available specifically to graduate programs for renovations and expansion. Research laboratories, clinical practice laboratories, and facilities for patient and group teaching all serve to increase necessary skills for specialty practice.

The American Nurses' Association continues to urge support for programs that increase access to nursing education programs, especially those assisting individuals from disadvantaged backgrounds.

Summary

According to the most recent inventory of registered nurses conducted by the American Nurses' Association, for the period 1977 to 1978, approximately 75 per cent of the country's licensed registered nurses are employed in nursing. This demonstrates a significant 13.3 per cent increase since 1962. Moreover, various studies indicate that the unemployment rate among nurses is exceptionally low compared to the national unemployment rate.

In spite of the fact that nurses are working, there continue to be unmet demands in the health care system for nursing services. While it is important to

focus attention on the numbers of active nurses in this country, it is even more important to concentrate on the demands for nursing services.

The nation cannot afford to utilize nurses, its largest group of health professionals, at anything less than their highest capacity. At the same time, a people who rightfully demand the best health care possible must be willing to support the efforts needed to provide such care. Such support comes through the funds provided for sound nursing education.

1. Report of the Secretary of Health, Education and Welfare on the Supply and Distribution of and Requirements for Nurses as required by Section 951, Nurse Training Act of 1975, Title IX, Public Law 94-63, March 15, 1979.
2. ANA, The Nation's Nurses: 1977-78 Inventory of Registered Nurses. Contract #H.R.A. 230760279.
3. _____ Health United States, 1979. U.S. DHEW PHS Office of Health Research, Statistics and Technology. publ.#(PHS) 80-1232.
4. Ibid.
5. Inventory
6. Foster, John F. "The Dollars and Sense of an All R.N. Staff". Nursing Administration Quarterly. Vol. 30, No. 1, Fall 1978.
7. _____ NLN Nursing Data Book '79. National League for Nursing, Division of Research. Pub. #19-1797, 1980.

STATEMENT OF SALLY AUSTEN TOM

Ms. TOM. Good afternoon. My name is Sally Tom, and I am a practicing certified nurse-midwife. I am representing the American College of Nurse-Midwives, and I also today am speaking from my experience as a nurse-midwife educator.

The first step toward becoming a professional nurse-midwife in the United States is to study nursing, and then practice nursing in the field of maternal and infant health for at least 1 year.

The future nurse-midwife then applies to a nurse-midwifery educational program, all of which are associated with major universities. Students who successfully complete their educational programs are eligible to take the American College of Nurse-Midwives certifying examination. All nurse-midwifery programs are accredited by the Division of Accreditation of the ACNM.

A considerable body of research documents the safety of nurse-midwifery care. All studies have shown that the risks to women attended by nurse-midwives is equal to or lower than the risk to comparable groups of women attended by physicians. In fact, the literature reports instances of striking reductions in infant mortality after introduction of nurse-midwifery care.

I would like to discuss with the committee how Congress can pursue its goal of providing quality maternal and infant child care in a cost-effective way.

The available data suggests that nurse-midwifery care is generally less expensive than traditional obstetrical care, and thus is a wise investment for Federal moneys. There is evidence that nurse-midwifery care often opens the door to lower cost through the use of nonhospital facilities such as birth centers or a patient's home for normal births, and through establishing early discharge programs.

Other data are limited. However, several characteristics of nurse-midwifery practice suggest that nurse-midwives offer cost-effective care. These include the lower average income of the nurse-midwife relative to a physician; reduction in neonatal mortality; limited use of technology; lower cesarean birth rate; and lower cost in establishing a new practice.

All of us in nurse-midwifery education are aware of the need for dependable financial resources. Nurse midwifery educational programs are turning to developing self-supporting faculty practices as a resource for financial support and clinical experiences for students.

There is, however, a tension between the need to shift the funding base and the political reality of opposition to nurse-midwifery practice. Resistance is widespread, it comes from many sources and takes varied forms. These include refusal to provide medical collaboration; refusal of permission or privileges to use hospital facilities; placement of unjustifiable restrictions on nurse-midwifery practice or settings; refusal of third-party payors to reimburse nurse-midwives; harassment of physicians who support nurse-midwifery practice; requests for unreasonable payments for liability insurance; and misrepresentation of the nature of nurse-midwifery practice to the public.

Opponents of nurse-midwifery care bring up two issues: The safety of nurse-midwifery practice and independent practice. The

record needs to be very clear on both issues. First, statistics document the safety of nurse-midwifery care. Nurse-midwives' record of reducing infant mortality proves that nurse-midwives are safe. Countries with lower infant mortality rates than the United States rely heavily on professional midwives.

Second, nurse-midwives do not practice independently in the model of the solo physician in private practice. Nurse midwives always have written contracts with obstetricians for consultation, collaboration and referral when complications arise; and nurse-midwives always practice within the bounds of medical protocols written by the nurse-midwife and her collaborating physician.

Until nurse-midwives are able to establish self-supporting faculty practice arrangements which put education programs on dependable, renewal financial bases, nurse-midwifery education programs will need Federal aid.

Until this country no longer has citizens who lack access to maternal and child health care and to safe option in maternity care, the Federal Government will need nurse-midwives.

Nurse midwifery services provide the Federal Government with a safety net upon which to depend in a time of budget cuts. Certified nurse-midwives are in part an antidote to the high cost of Federal maternal and infant health care programs.

Funds invested in nurse-midwifery education are moneys prudently invested and many times returned.

I want to thank the subcommittee for inviting the ACNM to testify today. The college looks forward to working with you in your efforts on behalf of mothers and babies.

Thank you.

[Testimony resumes on p. 200.]

[Ms. Tom's prepared statement follows:]

TESTIMONY
OF THE
AMERICAN COLLEGE OF NURSE-MIDWIVES

Good morning. My name is Sally Tom and I am a practicing certified nurse-midwife. I am representing the American College of Nurse-Midwives and am also speaking today from my experience as a nurse-midwife educator. I am on the faculty of Georgetown University's Graduate Nursing Program in the Growing Family, Nurse-Midwifery Specialty Area.

It is a pleasure to be here today. The ACNM would like to thank Chairman Waxman and Representative Mikulski for your successful efforts in passing Medicaid reimbursement during the last Congress. The College would also like to thank another member of the Energy and Commerce Committee, Representative Albert Gore, for his concern and work on behalf of childbearing families and nurse-midwives.

The American College of Nurse-Midwives (ACNM) is the professional organization of Certified Nurse-Midwives (CNMs) in the United States, representing 85% of all CNMs. The ACNM is autonomous from all other professional organizations and speaks for its membership on all issues affecting the practice, education, recognition, legislation and economics of nurse-midwifery. The ACNM collaborates with other professional groups which share its primary concern of quality maternal and infant health care for women and babies, and is recognized as an advocate for maternal and child health care issues.

According to the official ACNM definition, "A certified nurse-midwife is an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives. Nurse-midwifery practice is the independent management of care of essentially normal newborns and women, antepartally, intrapartally, postpartally and/or gynecologically. This occurs within a health care system which provides for medical consultation, collaborative management, and referral and is in accord with the 'Functions, Standards and Qualifications for Nurse-Midwifery Practice' as defined by the ACNM."

There are approximately 2,200 nurse-midwives in the United States, and approximately 220 more graduate each year. Most nurse-midwives practice in association with institutions such as hospitals, clinics, and birthing centers. A small number offer home birth services. In 1976-1977, nurse-midwives did approximately one percent of all births in the U.S.¹

Because these hearings focus on education programs, I want to describe the educational route a nurse-midwife takes. The first step toward becoming a professional nurse-midwife in the United States is to study nursing, and then practice nursing in the field of maternal and infant health for at least one year. The future nurse-midwife then applies to a nurse-midwifery educational program. Although all of these programs are associated with major universities, some are part of a Master's Degree program, and others grant a certificate rather than a degree. Both kinds of programs offer nurse-midwifery education which

prepares the student nurse-midwife for clinical practice. Students in Master's programs also receive further education in public health or nursing. Students who successfully complete their educational programs are eligible to take the American College of Nurse-Midwives' certification examination. Those who pass the examination are certified as nurse-midwives - CNMs. All nurse-midwifery programs are accredited by the Division of Accreditation of the ACNM.

Until the last decades of the 19th century, childbirth was in the hands of women. Midwives practiced an art and science passed from woman to woman. Mothers gave birth at home, surrounded by female friends and relatives, attended by a midwife who usually was also a friend or relative. A number of factors, including the rise of the medical profession, the growth of the public health movement, a trend toward limiting family size, the political vulnerability of midwives and their clients, the high infant and maternal mortality rates, and the severe decrease of immigration during and after World War I, combined to virtually eliminate traditional birth attendants and to move birth from the home to the hospital by the early 1900s. Maternal and child health became a national political issue when, during World War I, one third of all men were found physically unfit for military service and one half of those were thought to have suffered from poor maternal and child care. This experience during World War I and the political strength of newly enfranchised women brought about the passage of the Sheppard-Towner Act in 1921, creating the first infusion of federal dollars into maternal and child health care. In 1925, Mary Breckinridge, an American nurse educated in midwifery in England, established the Kentucky Committee for Mothers and Babies. A native Kentuckian, Mary Breckinridge became the country's first nurse-midwife and the committee became the Frontier Nursing Service, providing care for mothers and babies in mountainous, isolated Eastern Kentucky. Like the earlier midwives, nurse-midwives support the natural processes of health birth with watchful expectancy and emotional support. Unlike the midwife of past centuries, the certified nurse-midwife comes to her work after rigorous education offered by prestigious universities, bringing a scientific basis to her practice and an ability to identify and respond to deviations from the normal course of childbearing.

The number of nurse-midwives increased slowly between 1931, when the Maternity Center Association in New York opened the first nurse-midwifery education program, and 1970. By 1970, approximately 600 people had graduated from U.S. schools of nurse-midwifery. In the last 10 years the number of schools has doubled to more than 20 and an additional 1,600 nurse-midwives have graduated. Families' commitment to prepared childbirth, the assertion of consumers' rights and the resurgence of feminism have spurred a tremendous interest in nurse-midwifery care among consumers in the last decade. Consumers are demanding care which offers them decision-making power and reasonable options in childbearing. Meticulous screening throughout pregnancy and birth, combined with freely shared information and continuity of care, are the hallmarks of nurse-midwifery care. In addition, because of the uniquely female nature of childbearing, some

women seek nurse-midwifery care in order to receive care from women. In the last 20 years, women have acquired the education and strength to make changes in the health care system and nurse-midwifery has grown enough to be able to respond significantly to the demands women and their families make of health care providers. Consumers have been most vocal and ardent in their support of nurse-midwifery.

Only since the 1970's have professional midwifery services, which have long been available to women of all classes in other countries, been available to economically affluent women in the United States. Nurse-midwives are responding to increasing demands for nurse-midwifery care from affluent women by participating in a variety of private sector settings.

The federal government has a long history of support for nurse-midwifery. Several federal agencies rely heavily on nurse-midwives to provide care in their programs -- the Indian Health Service, Rural Health Clinics, the Maternal and Infant Care Projects, the National Health Service Corps, Improved Pregnancy Outcome projects, Adolescent Pregnancy Projects, and the Army, Air Force and Navy. Nurse-midwives receive direct reimbursement for services to military families under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and, thanks to diligent work on the part of the members of the House Interstate and Foreign Commerce Committee and to Senator Daniel Inouye, nurse-midwives will soon begin to be reimbursed for services to Medicaid clients.

Several recent federal government reports support nurse-midwifery practice. The Graduate Medical Education Advisory Committee's report recommended that nurse-midwives be doing 5 percent of all normal deliveries in the United States by 1990 and that federal support for nurse-midwifery education remain at its current level.² The current output of educational programs is not sufficient, however, to meet that goal. The report on necessary maternal and infant health services prepared for the Select Panel for the Promotion of Child Health focuses on nurse-midwifery services.³

The General Accounting Office's report, "Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome" describes nurse-midwives' effectiveness in delivering care to low income families. The report observes that "although HEW has endorsed use of nurse-midwives, the Health Services Administration has not aggressively promoted use of nurse-midwives in its programs."

The GAO recommended that "...HEW encourage a greater use of nurse-midwife obstetrician teams, help eliminate barriers which preclude nurse-midwives from practicing in hospitals, and provide additional training funds for nurse-midwives, by giving such training higher priority for use of existing funds and/or seeking additional funds from Congress."⁴ HEW agreed that better training and practice opportunities are needed for nurse-midwives and promised to convene a working group of HEW

operating agencies to develop by March 1980 a plan to promote greater use of nurse-midwives. This plan has not yet been developed, however, the working group has held one meeting and two consultations with nurse-midwives.

The safety of nurse-midwifery care has been well established. At a hearing held December 18, 1980, by the Subcommittee on Oversight and Investigation of the Interstate and Foreign Commerce Committee, noted epidemiologist, C. Arden Miller said, "All of the studies I know confirm that the health benefits of care as rendered by nurse-midwives stand up to scientific scrutiny exceedingly well." He added that many of the interventions routinely used in obstetrics today have been subjected to a scientific scrutiny which "...is in many respects less rigorous than the scrutiny to which the midwife's services are subjected."⁵ A considerable body of research documents the safety of nurse-midwifery care. All studies have shown that the risk to women attended by nurse-midwives is equal to or lower than the risk to comparable groups of women attended by physicians. In fact, the literature reports instances of striking reductions in infant mortality rates after introduction of nurse-midwifery care.

Since its beginning in eastern Kentucky, nurse-midwifery care has been introduced to other medically underserved areas characterized by poverty, geographical isolation and other social factors associated with poor obstetrical outcomes. Nurse-midwives screen carefully for indications of medical problems and collaborate closely with physicians when complications arise, thus identifying clients who are essentially medically normal from among the population characterized by social risk factors. Nurse-midwifery care has been shown to increase utilization of prenatal care, lower infant mortality and morbidity and to increase maternal well-being among these populations.

At the Frontier Nursing Service "...the maternal mortality rates averaged 9.1 per 10,000 births from 1925-1951; among white women nationwide the maternal mortality rate was 34 per 10,000. Since 1951, the FNS has not lost a single mother to birth related causes. FNS neonatal mortality rates in the years 1952-1954 were 17.3 per 1,000 -- less than the rest of Kentucky and the United States. Since 1971 the FNS perinatal mortality rates have averaged only 6 per 1,000 which is less than half the average of the rest of the country, even in its best year (14.5 in 1977), and better than the best country in the world, Sweden. The Metropolitan Life Insurance Company of New York estimated in a report in 1932 that if services like the FNS were adopted nationwide, the perinatal mortalities of the time would be reduced by 60,000 per year."⁶

Nurse-midwifery services in other rural areas, especially in the South and Southwest, have produced similar improvements in pregnancy outcome. The Medical Mission Sisters founded the Catholic Maternity Institute in 1943 to serve the impoverished mothers of Santa Fe County, New Mexico. The Sisters offered prenatal care and births at their Childbearing Center. Many births also took place in adobe homes with no electricity or running

water. Prior to the program, in 1939, perinatal death rate of Santa Fe County were 87.6 per 1,000. By 1967 it had been reduced to 15.1, a level of achievement not to be attained by the country at large until over 10 years later. At that time, in 1967, the perinatal mortality rates of the United States were 22.1 per 1,000, while in New Mexico it was even higher at 24.8..."⁷

In the early 1960's a CNM practice was established as a pilot project in Madera County, California. Special legislation made nurse-midwifery legal for the duration of the project. Certified nurse-midwives were introduced as the only new variable in the medically understaffed county's health care system. The mothers served by the project were primarily agricultural workers.

During the first 18 months of the project, the Madera County prematurity rate dropped from its previous level of eleven percent to 6.6 percent and the neonatal mortality rate dropped from 23.9 deaths per 1,000 live births to 10.3 deaths per 1,000 live births. There was a significant increase in attendance at prenatal clinics during the pilot project. Mothers who had had no prenatal care and who were cared for during labor and delivery by nurse-midwives experienced a neonatal death rate of 26.8 per 1,000 live births. The neonatal death rate for mothers who had no prenatal care was 50.6 per 1,000 live births after the project ended and nurse-midwifery care during labor was no longer available.

Despite these good results, the California Medical Society opposed legalization of nurse-midwifery and the nurse-midwives had to leave at the end of the project. After they left, the prematurity rate increased by almost 50 percent and the neonatal death rate tripled.⁸

In Holmes County, Mississippi, in 1971 the infant mortality rates had dropped from approximately 39 per 1,000 live births to 20 per 1,000 live births, two years after certified nurse-midwives began providing primary care to pregnant women as part of a community-wide focus on the health problems of mothers and babies.⁹

A study by the University of Mississippi Medical Center between October 1, 1972, and April 30, 1973, showed that nurse-midwifery clients kept 94 percent of scheduled appointments, compared with 80 percent of visits kept by clients of the house staff physicians. It should be noted that clients of both physicians and nurse-midwives did not see the same care providers at successive visits.

Among the nurse-midwifery clients 82.6 per cent had normal spontaneous vaginal deliveries; 62.1 percent of the house staff clients had normal spontaneous deliveries, with most of the difference found in the rate of low forcep deliveries by the house staff.¹⁰

At Su Clinica Familiar, a nurse-midwifery childbirth center in southern Texas, all maternity care for normal mothers is provided by certified nurse-midwives. The prematurity rate in 1974, two years after nurse-midwifery began, was 3.5 percent. In the same year in Texas

the prematurity rate was 7.6 percent and for the nation it was 7.4 percent. The nurse-midwifery service has been operating since 1972. The clients are Mexican-American and Mexican women who are primarily migrant workers. 11

"In 1976 a nurse-midwifery program was begun in Mississippi County in northeast Arkansas. In 1975, 80 percent of births had occurred under general anesthesia in that county. In 1979 general anesthesia rates had fallen to 12 percent, while perinatal mortalities also dropped dramatically. 12

"In 1941 the Tuskegee School of Nurse-Midwifery opened in Alabama offering services to the area. During the five years of its existence, neonatal mortality rates went from 46 per 1,000 live births to 14 -- more than a three-fold improvement."13

Nurse-midwifery services have also resulted in lowered infant mortality and morbidity rates among inner-city mothers.

In 1931, the Maternity Center Association (MCA) opened the Lobenstine Midwifery Clinic to care for immigrant families in upper Manhattan tenements. Between 1931 and 1951, 5,765 mothers registered with the clinic, of which 87 percent gave birth at home attended by (nurse-)midwives. Their maternal mortalities were less than one-third the national rates of the time. Their average neonatal death rates were only 15 per 1,000 while that of New York City as a whole ranged from 28.0 in 1931 to 18.4 in 1951." Kings County Hospital, New York City, opened a nurse-midwifery service in 1976. In the first 884 births, they had a neonatal mortality rate of 7.9 per 1,000, reflecting the deaths of 7 premature babies.14

At the North Central Bronx Hospital, whose clients come from one of New York's most distressed areas, where every patient receives nursing care or nurse-midwifery management from nurse-midwives in labor, from January 1 to December 31, 1979, 88 percent of the mothers experienced normal spontaneous vaginal deliveries. Less than 30 percent of all mothers needed analgesia or anesthesia in labor. The neonatal death rate among infants 1,000 grams or over was 4.2 per 1,000. 15

Since 1970, nurse-midwifery practice in the United States has expanded to include two additional special populations, adolescents and economically affluent women. Adolescent childbearing carries social and medical risks which can often lead to poor obstetrical outcomes. Nurse-midwifery care, along with physician collaboration has been effective, and has been shown to improve the outcomes of teenage pregnancy.

Between 1976 and 1977 at a clinic for teenagers in Lincoln Hospital in New York City, nurse-midwifery care brought considerable improvement in outcome measures such as maternal weight gain and hematocrit. The rate of low birth-weight babies dropped from 18.1 percent to 6.3 percent.16 The Office of Adolescent Pregnancy at the Department of Health and Human Services has stressed inclusion of nurse-midwifery services in the projects it funds.

The first part of this testimony documents the safety and high quality of nurse-midwifery care. I would like now to open a discussion with the Subcommittee about how Congress can pursue its goal of providing maternal and child health care in a cost-effective way. The available data suggest that nurse-midwifery care is generally less expensive than traditional obstetrical care.

A study conducted in rural Georgia showed significant improvement in infant outcomes and a decrease in health care expenditures after introduction of nurse-midwifery care.¹⁷

Nurse-midwifery care often opens the door to lowered costs through the use of non-hospital facilities, such as a birth center or the client's home, for normal births. The Blue Cross/Blue Shield of Greater New York audited the Childbearing Center started by the Maternity Center Association in New York City in 1976-1977. They found that care at the Childbearing Center cost 37.6 percent of in-hospital care, barring complications. The report also stated that the cost to Blue Cross/Blue Shield of Greater New York for families delivering at the Center was 66.1 percent of the cost to the plan had the family gone to the hospital, barring complications.

The cost to the health care system of full care at the Center has decreased each year, from a high in 1976 of \$2,016.46 to \$1,046.17 in 1979, as utilization increased. The Childbearing Center staff expect the Center to be self-supporting with 600 families in the program annually. In late 1980 the Center had over 500 families enrolled and expected to meet their goal very shortly.

Medicaid is currently paying from \$1,649.53 to \$2,230.04 for normal care with a three-day hospital stay in various New York hospitals. The Childbearing Center currently charges \$1,000 for its whole package of prenatal, intrapartum and postpartum care; the Center receives \$885 for total care from Medicaid and the Center is appealing that rate.

The care at the Center is economical because clients have the opportunity for prolonged contact with professionals, including the nurse-midwives who are with them in labor and delivery. A client's stay at the Center is much shorter than the typical three-day stay and she receives intensive, personalized care during that time.

The Center is also economical because non-hospital facilities, the Center and the client's homes are used as settings for provision of care. The Center's all inclusive fee of \$1,000 compares favorably with the \$3,000 for hospital and obstetric fees which private care in New York City can cost.¹⁸

Another mechanism often associated with cost savings and midwifery care is the shortened hospital stay for a healthy mother and baby. Midwifery care during pregnancy and availability by phone or home visit during the early postpartum period set the stage for the well-prepared family to go home within 12 to 24 hours after a normal labor and birth.

In Washington, D.C. the current cost of prenatal, delivery and postpartum care with a nurse-midwifery service is \$800 for clients planning to deliver in the hospital. This includes prenatal care, labor management and delivery, postpartum care, a two week, six week, six months and one year checkup and three postpartum classes. Physician's fees vary from \$800 to \$1,200 and include prenatal care, labor and delivery management, postpartum care, and a six weeks check-up. Hospital costs for nurse-midwifery clients who spend 6 hours or less in the hospital after delivering, are around \$600. Clients who stay the traditional three days will pay close to \$1,000 in hospital costs.

Most nurse-midwives are employees who have no control over prices charged to clients. As more nurse-midwives go into practice with physicians and establish private nurse-midwifery practices, we will begin to be able to assess the financial impact of private nurse-midwifery practice. CHAMPUS began reimbursing nurse-midwives within the past year and is conducting a study of the impact of nurse-midwifery reimbursement on their maternity care costs.

While the data are limited, several characteristics of nurse-midwifery practice suggest that nurse-midwives deliver cost-effective care. The average salary of a nurse-midwife in clinical practice in 1976 was \$16,200. Contrast this figure, which has certainly improved somewhat since 1976, with the median income of any obstetrician-gynecologist, which was \$89,310 in 1979. Nurse-midwives' services have to cost employing institutions less than obstetricians'.

As we have seen earlier, nurse-midwives have a proven record in reducing infant morbidity and mortality. The reduction in prematurity and low birth weight rates in the many places nurse-midwives have worked certainly must also have meant a reduction in dollars spent by states and private companies on intensive care nurseries.

Nurse-midwives are educated to use technology only when it is indicated by a client's condition. Such limited, rather than routine, use of machines and laboratory tests should result in savings for individual customers. Nurse-midwifery clients often use less analgesia or anesthesia in labor, thus saving the costs of drugs, procedures and anesthesiologist fees.

A Cesarean birth can add as much as \$1,000 to a physician's fee and as much as \$3,000 to hospital fees. Nurse-midwifery services have Cesarean birth rates which are significantly lower than the U.S. rate which is approaching 30 percent in many facilities. The Cesarean birth rate at the nurse-midwifery service at the North Central Bronx was approximately 13 percent in 1979, for example.

A nurse-midwifery service would be less expensive than a physician's practice for the federal government to establish because nurse-midwives need less complicated equipment. They need only to have access to high technology through their collaborating physician.

In addition to potential cost savings, nurse-midwives bring to each birth a concern for the psychological and cultural factors which affect the birth experience of the mother, family and infant. Ample research has shown that the nature of the birth and immediate post-birth experiences have a strong impact on later infant-parent relationships. The evidence suggests that positive birth experiences correlate with lower incidences of child neglect and abuse. Nurse-midwives strive to help parents create positive birth experiences and this must make an indirect contribution to lowered financial and emotional costs to society as a whole.

The information available and the logical conclusions drawn from examination of nurse-midwifery practice prove that nurse-midwifery care is a cost-effective means to providing safe, satisfying maternal and child health care.

An investment in nurse-midwifery education is then, one which brings good returns to Congress and to American families.

Congress invests in nurse-midwifery education through the Nurse Training Act via the aid to students through National Health Service Corps scholarships, general scholarships, Advanced Nurses Training and Nurse Practitioner traineeships. Aid to educational programs comes through Nurse Practitioner education programs, Advanced Nurse Training programs, special projects money and probably indirectly through undergraduate capitation money.

At least 12 nurse-midwifery education programs receive major parts of their funding through the Nurse Training Act. It costs approximately \$16,000 to \$18,000 to educate a nurse-midwife; tuition for a master's degree program can be almost \$5,000 a year and the longest programs are two full years, including the summer semester.

All of us in nurse-midwifery education are aware of the need for dependable funding sources. Directors and faculties of nurse-midwifery education programs are devising strategies for shifting their funding base from soft money to hard money. All faculties would like to be fully supported on hard money by their universities, as are the programs at St. Louis University and University of Kentucky. Since most university budgets will not permit that kind of full support, nurse-midwifery educational programs are turning to developing self-supporting nurse-midwifery services as a means of finding financial support and clinical experiences for students.

Nurse-midwifery education lends itself easily to this model because nurse-midwifery is largely taught in the clinic and at the bedside. Faculty must practice in order to teach nurse-midwifery; these same faculty, with accompanying students, could be reimbursed either through Medicaid or through private insurance plans. A faculty which had a practice large enough to offer students the necessary clinical experiences would be

supplying a substantial part of its own salary. The university would then fund the non-clinical teaching activities, such as conducting seminars, curriculum revising, student counseling and program administration.

Financing nurse-midwifery education through private faculty practice is a concept which many programs are exploring. There is, however, a tension between the need to shift the funding base and the political reality of opposition to nurse-midwifery practice.

Among the six obstacles to greater federal utilization of certified nurse-midwives, the limited supply, few training programs, reluctance of some nurse-midwives to practice in less desirable areas, restrictive state licensing or third party reimbursement, non-availability of obstetricians with whom to work, physician resistance is the most difficult problem.¹⁹ This problem was recently the subject of an investigatory hearing held by the Subcommittee on Oversight and Investigation of the Energy and Commerce Committee and chaired by Congressman Gore.

The resistance occurs despite the demand for nurse-midwives by consumers, state governments and federal agencies, despite the record of improved health for mothers and babies, despite cost effectiveness and despite the widespread employment of nurse-midwives through the country. Resistance to nurse-midwifery practice is strong and seems to be gathering strength.

While I am describing this resistance in some detail, I hope you will keep in mind the co-existing reality that in many communities nurse-midwives, physicians and hospitals have formed mutually satisfying professional relationships. The ACNM and the American College of Obstetricians and Gynecologists (ACOG) often work together on issues of importance to mothers and babies. The ACNM has benefited from and appreciated ACOG's official support. Nurse-midwifery practice was officially endorsed by the American College of Obstetricians and Gynecologists (ACOG) and the Nurses Association of the American College of Obstetricians and Gynecologists in a statement issued jointly with the ACNM in 1971 and in a supplemental statement in 1975.

The incidence of resistance is widespread and has been found in recent months in Massachusetts, New York, New Jersey, Pennsylvania, Washington, D.C., Maryland, Delaware, South Carolina, Tennessee, Illinois, and South Dakota. Resistance comes from many sources: individual physicians, professional organizations such as medical societies, hospital departments of obstetrics, public bodies such as state boards of health and state medical practice boards, insurance companies, and occasionally nursing.

The form which the resistance takes varies as well. It includes refusal to provide medical collaboration, refusal of permission or privileges for use of hospital facilities, placement of unjustifiable restrictions on nurse-midwifery practice or settings, refusal of third party payors to reimburse nurse-midwives, harassment of physicians who support nurse-midwifery practice, request for unreasonable payments for

liability insurance and misrepresentation of the nature of nurse-midwifery practice to the public.

-In Washington, D.C. Georgetown University Medical Center has consistently refused to allow nurse-midwives to practice in labor and delivery, even though the school of nursing has had a nurse-midwifery education program for several years.

-In New Jersey the Board of Medical Examiners has issued regulations which restrict nurse-midwifery practice and which prohibit nurse-midwives from caring for women under 16 and over 35 years of age. These regulations have a severe impact on nurse-midwives and their clients, especially adolescents, in New Jersey.

-In Nashville, Tennessee the two nurse-midwife members of an obstetrician-nurse-midwife team were denied privileges at three hospitals in which their physician practiced. Their physician experienced such strong harassment from his colleagues, including cancellation of his insurance by the physician owned malpractice insurance company, that he has left Tennessee. No other physician in Nashville is willing to collaborate with nurse-midwives in private practice. The nurse-midwives have been forced to close their business and undertake expensive legal action. They will be filing suit in a few weeks.²⁰

-When Maternity Center Association in New York City opened its Childbearing Center, an out of hospital birth center, they did so despite the opposition of a wide array of state agencies, state physicians' organizations and national physicians' organizations.²¹

-In Englewood, N.J., the Childbirth Center has struggled to survive in the face of opposition from local physicians, the Board of Medical Examiners and a major insurance company.²²

-In Washington, D.C., a private group practice of three nurse-midwives who do home births embarked a year ago on a pilot experiment doing hospital births at the Washington Hospital Center. In order to obtain privileges the nurse-midwives became technically the employees of their collaborating physicians who already had privileges. Although the first year went well, the hospital's Department of Obstetrics and Gynecology voted to end the nurse-midwives' privileges because they are also doing home births. The decision has not been carried through by the hospital's board of directors because of the large public outcry against the decision. The Department of Obstetrics has formed a committee to review the nurse-midwives' charts. There are no nurse-midwives or pediatricians on the committee.²²

While scores of rationales for these obstacles exist, and each incident is flavored with its own particular legal, administrative and interpersonal characteristics, two themes emerge from the arguments against nurse-midwifery practice. The first of these is the issue of quality of care and of patient safety. The rare, and often preventable occurrence of a complication of pregnancy or birth is often cited as the reason for preventing nurse-midwives from practicing or for limiting

the scope of their practice to less than that for which they have been educated. Two assumptions underlie that rationale. The first is the idea that while nurse-midwives are better than no prenatal or intrapartum care at all, the physician is always more desirable because of his or her education in dealing with complications. The statistics refute that claim. The record of nurse-midwifery care in the United States in reducing infant mortality and morbidity shows that nurse-midwives are safe. Countries with lower infant mortality rates than the United States' rely heavily on professional midwives.

The second underlying assumption is that the speed with which severe complications arise is great enough to justify physician presence throughout labor and delivery managed by nurse-midwives. It is important to remember that pregnancy and childbirth are normal physiological practices. Normal, healthy pregnancy and delivery are the predominant realities of childbearing. Complications are the exceptions, not the rule. Nurse-midwives, unlike most physicians, are able to be in constant attention throughout labor. Thus, nurse-midwives detect problems at the earliest moment and often avert them. Extremely serious complications which develop rapidly are extremely rare. Many common complications of labor and delivery result from the routine interventions of traditional medical care which do not characterize routine nurse-midwifery care. Nurse-midwives are educated to recognize the symptoms of complications, to begin the appropriate interventions and to call for assistance immediately when complications arise.

The second theme which emerges in the resistance of nurse-midwifery practices is that of "independent practice." Licensure, direct third party reimbursement, home birth services and out-of-hospital birth centers all raise the question of whether nurse-midwives are, or should be, "independent practitioners." "Independent practice" appears to mean a nurse-midwife hanging up her shingle in a solo practice patterned after the independent business of the solo physician in private practice. The implication of this model is that the nurse-midwife would be practicing without back-up physician, without the system for consultation with physicians, referral of clients to physicians and without the collaborative management of client care by both a nurse-midwife and a physician which are an integral part of the definition of nurse-midwifery practice. The record needs to be very clear on this matter. Nurse-midwives do not practice midwifery in the "independent practice" model of the private solo practice which characterizes much physician practice. The "Functions, Standards and Qualifications for Nurse-Midwifery Practice" states that nurse-midwifery practice "Occurs interdependently within a health care delivery system. Occurs within a formal written alliance with an obstetrician; or another physician, or a group of physicians, who has/have a formal consultative arrangement with an obstetrician-gynecologist; exists within a framework of medically approved protocols."

The dictates of the "Functions, Standards and Qualifications for Nurse-Midwifery Practice" are clearly explained by Helen Varney, the current president of the American College of Nurse-Midwives in her recently released textbook of nurse-midwifery. "'Independent management' refers

to the fact that a patient may never see a physician if her course essentially is normal and she is managed by a nurse-midwife. Thus, the practice of nurse-midwifery within the protocols for practice, which define the practice and provide for medical consultation and referral is independent. . . Independent practice means without medical protocols of formalized physician back-up. A certified nurse-midwife always functions within a health care system in a team relationship with a physician and is never independent of physician back-up for consultation, collaborative management, or referral."²³ Should a nurse-midwife be thought to be violating the principles established in "Functions, Standards and Qualifications," she would be subject to investigation by the American College of Nurse-Midwives and would be vulnerable to censure, suspension, expulsion or decertification.

Nurse-midwives have always practiced and will continue to practice in collaboration with physicians; that relationship will not change. What has begun to change, however, is the employment relationship between the nurse-midwife and her collaborating physician. Nurse-midwives are now not always employees of physicians or hospitals. In some cases the nurse-midwife has joined the practice of her physician partners. In other cases, nurse-midwives are employing physicians to provide them with consultation and referral services. Nurse-midwives are increasingly eligible for direct third-party reimbursement. Many private insurance companies including Connecticut General, Travelers, Aetna, and all union insurance programs, will reimburse nurse-midwives in all states. New Mexico, Utah and Maryland have adjusted their insurance codes to include direct reimbursement to nurse-midwives. CHAMPUS and Medicaid now reimburse nurse-midwives. All of these changes mean that a nurse-midwife may become economically independent of her physician or hospital back-up services. Her professional interdependence with physicians and hospitals remains and always will.

Until nurse-midwives are able to establish self-supporting faculty practice arrangements which put education programs on dependable, renewable financial bases, nurse-midwifery education programs will need federal aid.

Until this country no longer has citizens who lack access to maternal and child health care and to safe options in maternity care, the federal government will need nurse-midwives.

Nurse-midwifery services provide the federal government with a safety net upon which to depend in a time of budget cuts. Certified nurse-midwives are in part an antidote to the high cost of federal maternal and infant health care. Funds invested in nurse-midwifery education are moneys prudently invested and many times returned.

The following are specific recommendations for your consideration during discussion of the Nurse Training Act.

1. Increase funding for the Nurse Training Act, including for Advanced Nurse Training programs, Nurse Practitioner programs and Special Projects.

Rationale: The increasing economic stress of our time will create an increasing need for nurse-midwives to serve disadvantaged populations. An increased number of nurse-midwives will be needed to meet the needs of these populations and to meet the GMENAC projections.

2. Increase funding for National Health Service scholarships and jobs; change the eligibility requirements to include certificate program as well as masters degree program students.

Rationale: The NHSC is a cost-effective means of providing care to medically underserved areas. Nurse-midwives are appropriate members of the Corps because of their ability as health educators as well as providers, and their suitability for areas which cannot attract an obstetrician or for areas which can support an obstetrician and a nurse-midwife but not two obstetricians.

3. Increase funding for scholarships and student loans.

Rationale: The \$2,500 a year available through loans to eligible students and the \$2,000 available through scholarships are not enough aid to help most disadvantaged students enough to enable them to enroll.

4. Continue the special mention of nurse-midwives in Advanced Nurse Training traineeships and add the same mention to traineeships for Nurse Practitioners.

Rationale: This recognition highlights the Congressional support for nurse-midwifery practice.

5. Continue the change which makes it possible for students who do not come from underserved areas but who are willing to go to such areas after graduation to be eligible for Nurse Practitioner traineeships.

Rationale: Many students seek traineeships which have been limited to students from underserved areas and these students are quite willing to move to underserved areas after graduation.

The American College of Nurse-Midwives is pleased to have been invited to testify here today. We will look forward to working with the Subcommittee on Health and the Environment in your future efforts on behalf of mothers and babies.

Thank you!

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Mr. WAXMAN. I thank you both very much for your testimony today, and also I want to acknowledge the presence of Dean Helen Grace for the League for Nursing is here to answer questions, along with Dean Rosemary Donley for the American Association of Colleges of Nursing; and Mary Copeland, for the National Student Nursing Association.

Thank you for your testimony. I have no further questions of you, but let me call on Mr. Benedict.

Mr. BENEDICT. Thank you, Mr. Chairman.

Just briefly, Ms. Holleran, I have got some numbers from a group known as the Division of Health Professional Analysts. I'm not sure I can vouch for them, but they have some numbers on the number of practitioners in your profession.

They indicate that as of 1980, about 1,152,000, and they project a need by 1990 of 1,157,000; a very small increase, in other words.

Do you feel it's appropriate for the Federal Government to continue its efforts in education, the nursing education at the high levels it has been in view of the fact we are so near to the needs of 10 years down the road?

Ms. HOLLERAN. There have been several studies done. The particular one you called out, I am not familiar with. There was one done by the Western Interstate Commission that looked at nursing dependent on what happened in the health care system and made projections, and their figures are considerably higher than that.

Mr. BENEDICT. In terms of need at 1990?

Ms. HOLLERAN. In terms of which the need has speeded up in the health care field. I would point out that since 1977, enrollments in nursing schools have declined steadily, and we think there is a direct relationship there to the cutback in Federal funding.

In 1977, it was cut even greater, and in 1978 and 1979, and we are concerned about the trend. It's the first time in some 15 years that we have seen a decline.

Mr. BENEDICT. Is there any problem with unemployment?

Ms. HOLLERAN. Nurses could find 10 jobs apiece.

Mr. BENEDICT. Ms. Tom, you touched on a problem of resistance to your profession from physicians, hospitals, and insurance companies. As we continue to educate more physicians, and we have heard that there is likely to be a surplus in the foreseeable future, will this not aggravate your problem?

Ms. TOM. It may. There are several reasons for the problem. One is that there are still not very many nurse-widwives in the country, and most physicians have not met a nurse-midwife, and when she is introduced into the community, there is need for a tremendous educational effort.

We have found, and studies have shown, that to know us is to love us.

Ms. MIKULSKI. That's the way we feel about Members of Congress.

Ms. TOM. We have found that resistance does decrease with acquaintance.

Also, I think some physicians are finding that it is to their benefit to ally themselves with nurse-midwives, that physicians are trained to be specialists in the care of the ill, and that nurse-midwives working in teams with obstetricians enable them to

spend more time with their ill patients and less time with their well patients. And most pregnant people are indeed very healthy and well.

So I believe this will continue for at least some period of time and I think there are factors that will mitigate against it.

Mr. BENEDICT. Would it be appropriate to channel Federal assistance in these fields more toward your profession?

Ms. TOM. Well, my understanding with discussions at the Division of Nursing is that at any time a nurse-midwifery program has requested funds, it has received a very fair evaluation with the Division of Nursing. I think we feel have been treated fairly on the allocation of money, and making us a specific line item would perhaps not be to our advantage.

Mr. BENEDICT. Do members of your profession provide services in inner cities and rural areas to the structurally underserved?

Ms. TOM. Yes, I believe we do.

Mr. BENEDICT. Can you support that?

Ms. TOM. Yes; I have a statistic here for you; 59 percent of all certified nurse-midwives, in our most recent survey, which was in 1976-77, work in communities of 500,000 or less. Our traditional constituency has been what we called medically underserved.

It's only within the last 10 years that our patients come out of the more affluent sector and we've been in this country since 1925.

Mr. BENEDICT. You could add my whole district together in one place, and it still wouldn't fit that.

Thank you.

Ms. GRACE. I would like to speak to that program. We have a graduate program in nurse-midwifery service in Chicago at Cook County Hospital. We deliver one-third of all the deliveries in Cook County Hospital, and also do extensive work in the structurally underserved areas.

Mr. WAXMAN. Ms. Mikulski.

Ms. MIKULSKI. Thank you very much.

I have some general questions related to anyone on the panel who would care to answer.

What is the average tuition for a nursing student? What does it cost a woman to educate herself in the field of nursing?

Ms. COPELAND. Being a student, perhaps I should answer that. The average cost in a private institution varies from \$5,000 to \$8,000 a year.

Ms. MIKULSKI. What is a private institution?

Ms. COPELAND. In an independent private school, not a State university or community college.

Sister DONLEY. Catholic University, where I am dean, the University of Maryland in your area, is a State school. If one is a resident of the State.

Ms. MIKULSKI. So in a private school it's \$5,000 to \$8,000 a year for tuition, and then there are more expenses. So are you in a 2-year program?

Ms. COPELAND. I'm in a 4-year program in a private school.

Ms. MIKULSKI. So then when you graduate, you will have spent approximately \$32,000 to get your education, and then what is the average starting salary of a nurse in the United States?

Ms. COPELAND. \$13,000 to \$15,000.

Ms. MIKULSKI. I see.

So if we think of the ratio of annual reimbursement to tuition expenditure, and considering that the average doctor makes \$50,000 a year upon graduation, then \$50,000 a year tuition in medical school would be the proper framework in which to discuss investment in a person's education as it relates to later financial remuneration. Is that a fair analogy?

Ms. COPELAND. You could look at it that way.

Ms. MIKULSKI. I'm being very serious here. What is the tuition in State universities? Could we take a Midwestern range?

Ms. GRACE. Well, it varies a great deal.

Ms. MIKULSKI. What is the range?

Ms. GRACE. \$2,000 would be about the average in the State institution.

Ms. MIKULSKI. \$2,000 for what?

Ms. GRACE. Per year. I think that State tuitions are going up the same way as private tuitions, so \$2,000 to \$5,000.

Sister DONLEY. And if one is out of State and attends a State school, he or she pays this out-of-State tuition which is very comparable to the private schools.

Ms. MIKULSKI. The average cost of educating a nurse can range from \$20,000 to \$32,000, and the average starting salary is \$13,000. That's just a few thousand dollars a year over CETA or a unionized checkout person.

Sister DONLEY. In some areas nurses make less than bus drivers. Many public servants make much more than nurses.

Ms. MIKULSKI. Now, looking at the supply side of economics, one of the things that we face is that, because nursing is primarily a woman's profession, a nurse's career is a cyclical and as episodic as any other woman professional—out of school and educated, practice for a few years, out to have a few children, back into the labor market, et cetera—there is a need also for ongoing education. Projected linear figures don't give an adequate picture of the availability of nurses, because by the very fact that we are a motherhood field, you cannot say we are there all the time, even though we might be on the books.

The figures tend to be exaggerated in terms of actual availability of service. Is that right?

Ms. HOLLERAN. Also we are facing a period of a large number of retirements we need to take into account, because of the big influx of nursing people during World War II, and that group being ready to retire.

Sister DONLEY. If one drops out of practice for 5 years to raise a child, when she comes back into practice, because it's a highly technical field, the practice has greatly changed, and so it's not like you can leave for a couple of years and come right back in. Then there is a need for some kind of continuing education.

Ms. MIKULSKI. This takes me also to how do we get the most service for the most public investment? Would you see as part of our scholarship program perhaps more emphasis also on continuing education for the returning nurse as one way of meeting nursing shortages and making maximum use of people already trained?

And, second, what about the desirability of attracting the older woman, whose children are grown, into the field of nursing? A

woman who brings a great deal of maturity and life experience and who could go to a 2-year program at community college. Do you think we should attract the woman who, because she is putting her own kids through college, might not have the money to pursue her own education?

Ms. GRACE. I think this is a whole new population that is appearing in nursing programs, the woman who is entering the profession for the first time at age 40. And I think it's an area that needs to be supported.

Ms. MIKULSKI. So you think there is a real need for this?

What do you think the country would get out of that if we did it?

Ms. HOLLERAN. We have had a few projects that focused on this 6 or 7 years ago that were funded, and I think they found that they were very motivated, they were career-committed, and they were in permanently.

Ms. MIKULSKI. Would they also be likely to work in the underserved areas?

Ms. HOLLERAN. Many of them do go back to the area which they have come from, in order to practice, yes.

Ms. MIKULSKI. I see. Thank you very much. Being 44 myself and limited to a 2-year term, I'm interested in scholarships.

Mr. WAXMAN. Thank you, Ms. Mikulski.

Mr. Whittaker.

Mr. WHITTAKER. Thank you, Mr. Chairman.

Maybe to followup on my colleague's comment, I notice that you made a reference that nursing remains one of the lowest paid professions in the country. I want to ask how much of a deterrent do you believe that is to a student choosing a profession?

Ms. HOLLERAN. I think this is increasingly becoming a major factor. It used to be that women didn't have many choices, but now they do, and you are quite right, that unless the situation improves, you are not going to get many of the bright people to come into nursing as a long-term career.

Mr. WHITTAKER. What do you believe is the greatest obstacle toward receiving remuneration comparable to your abilities?

Ms. HOLLERAN. We frequently have heard that the increase in nursing cost is because nursing salaries have gone up. We don't think the salary increases have reflected the inflation rate.

I think the problem has been the structure of the institution and the lack of autonomy for nurses to practice as they see fit, and to have a voice in the management policies affecting the salaries.

Mr. WHITTAKER. On page 2, you mention five factors as contributing to what you term an acute nursing shortage. Can you describe what the Government's role should be in addressing these factors? Because parenthetically, as I look them over and study them, I am not certain the Federal Government really is best suited to address those issues.

Ms. HOLLERAN. The Federal Government could stimulate studies that need to be done in these areas. They have not been focused on even by a large group of employers. I think that kind of stimulation would do a lot.

Also I think if we could get some clinical demonstration centers going, when you look at the hundreds of millions of dollars that the Federal Government puts in Federal nursing services, they really

need to put some money into investigations and improvement in organization, and it would be a small cost factor, I think, and would pay off in 4 or 5 years.

Mr. WHITTAKER. Although I don't recall if you mentioned it specifically in your verbal testimony, we have heard references that the greatest need in nursing can be provided by the nonbaccalaureate graduate nurse. Would you care to address this issue as to what your feeling is as to the balance of need between the baccalaureate graduated nurse and the less-than-baccalaureate graduated nurse?

Ms. HOLLERAN. I'd be glad to. I think the type of practice we are talking about today is increasingly complex and you do need a mix of people. The nurse at the baccalaureate level is better prepared for the leadership role in that nursing service, working with people with a more technical preparation. There is a nursing team.

In other words, you can't substitute one for the other.

Mr. WHITTAKER. Do you foresee the day where you will have additional specialties within the nursing program in addition to the nurse clinician and the nurse-midwife?

Ms. HOLLERAN. I think if you look just at the care of the elderly that we are seeing an increasing demand for nurses with gerontological preparation and our schools need to address that more rapidly than they have.

Mr. WHITTAKER. I would like to make a comment, Mr. Chairman, personally directed to Ms. Tom. I compliment you on your testimony, and in spite of all we have to read, I'm going to try to read your entire single spaced multipage testimony.

Ms. Tom. Thank you.

Mr. WHITTAKER. I suspect, Mr. Chairman, that the entire subject of nurse-midwifery has been a subject of committee hearings in the past.

Mr. WAXMAN. Yes, it has, including legislative action.

Mr. WHITTAKER. I will look back and review what has transpired. It's very interesting. Thank you.

Mr. WAXMAN. Mr. Dannemeyer?

Mr. DANNEMEYER. My comments will be brief, Mr. Chairman, as a proponent of the supply side of economics.

Ms. MIKULSKI. I know.

Mr. DANNEMEYER. You should take comfort that the message has sunk in. Let me read a very small portion of the administration's recommendations relating to your profession.

The administration would propose legislation to focus on a limited number of national medical specialties, rather than providing large subsidies for all specialties. In addition, support for training in nonphysician specialties will be focused on occupations such as nursing, where shortages persist.

So you have friends in the White House, if that's of any comfort to you.

Mr. WAXMAN. Thank you all very much.

We have one additional panel.

Our last panel for today includes Dr. Edward Stemmler from the University of Pennsylvania, representing the Association of American Medical Colleges; Dr. Benjamin Cohen from the American Association of Colleges of Osteopathic Medicine; and Dr. Errol

Reese from the University of Maryland, representing the American Association of Dental Schools.

I would like to welcome all three of you to our hearing today. Again, we would like to request that you summarize your testimony in approximately 5 minutes so we can engage in questions and answers.

Dr. Stemmler.

STATEMENTS OF EDWARD J. STEMMLER, M.D., ON BEHALF OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ACCOMPANIED BY DR. JOHN COOPER, PRESIDENT; ERROL REESE, D.D.S., ON BEHALF OF AMERICAN ASSOCIATION OF DENTAL SCHOOLS; AND BENJAMIN COHEN, D.O., PRESIDENT-ELECT, AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

Dr. STEMMLER. I am Dr. Edward J. Stemmler, Dean of the University of Pennsylvania School of Medicine. Dr. John Cooper and I, the president of the American Association of Medical Colleges, are here to represent the point of view of that association. Given the time limits, I will restrict my comments to a synopsis of the association's key concerns, but request that the more lengthy explication of our position to be submitted within the next few days be entered into the hearing record.

Mr. WAXMAN. We will, without objection, receive that full text of the testimony you would like to have inserted in the record and put it in the record. [See p. 208.]

Dr. STEMMLER. Thank you, Mr. Chairman.

Clearly the country is deeply engaged in an examination of the economic constraints within which this Nation can operate. Central to this exercise is the question of the appropriate role of the Federal Government and the host of activities perceived as necessary to sustain or improve our Nation's social condition.

Let me summarize why the AAMC believes that the Federal participation in the complex enterprise of medical education represents an appropriate, as well as an important utilization of Federal resources.

First, and of course a paramount issue, is that the quality of health care received by the people of this Nation is ultimately dependent upon the excellence of education received by medical students.

The preeminent international stature that the United States enjoys in biomedical and behavioural research is directly related to the excellence of the educational institutions in which many of our countries' clinical investigators work.

The enhancement of this innovation and creativity is vital to our Nation's future.

Finally, past Government investment in these educational institutions has confirmed their value as instruments of change in the immediate and long-range implementation of national health policy.

This valuable function should not be abandoned.

The reauthorization of the very basic health manpower programs proposed by this bill are now more necessary than ever. Medical schools and affiliated teaching hospitals will in the next few years

be faced with unprecedented financial stresses, some of which could compromise their very existence.

Our institutions are dependent upon an interweaving of many diverse sources of revenue, many of which are insecure. The loss of any one or group of these cannot necessarily be made up by others.

I'll speak now to the student assistance issues. We make two basic assumptions that underlie our position on the future of student aid programs. The first, in view of their high income potential, all but the most impoverished students should ultimately be responsible for financing a significant portion of their medical education.

Second, the cost of obtaining a medical education is becoming almost prohibitive for the average individual. Absent a reasonably comprehensive portfolio of financial aid programs, the opportunity to secure an M.D. degree will be limited to only the affluent; that is those who are more accustomed to the notion of investing large sums for a future return.

Therefore, the association hopes that you will accord student assistance the highest priority in the development of a new statute, and we advocate that the new bill provide for an appropriately balanced set of student assistance programs for all qualified students seeking access to medical education, regardless of their economic status; that it provide manageable debt repayment options in recognition of the economic reality that initiation of repayment of loans is virtually impossible during school, and a serious hardship during the very early years of practice; that it provide an expanded opportunity for students to repay their indebtedness through loan forgiveness programs; and that you decouple programs assigned to meet national need, such as the National Health Service Corps, from the student aid programs.

The association is gratified that many elements of the student aid structure envisioned by the proposal before this subcommittee adhere to these principles.

I'll speak now to institutional support. The association's views on institutional support are well known. While currently computed on the basis of student population, we emphasize that it is not primarily a form of student subsidy. Institutional support is utilized for the stabilization of the medical center's entire mission, including service and community outreach programs through discretionary interventions.

The phaseout of institutional support proposed by this bill is, of course, of grave concern to our constituents. Institutional support, small as it is, is the only accessible uncommitted money available to many schools.

The true value of these funds exceeds by far their actual magnitude. The only resource funds to meet unexpected contingencies and emergencies and to develop new and innovative programs the nation so desperately needs to advance the health of our people.

The General Accounting Office report on the role of institutional support in medical education supports this.

On the other provisions of the bill, other than those that I have mentioned, while it has commented extensively on other important provisions in its full statement, the association at this time simply

wishes to emphasize that it believes that the system of special project grants has proven to be and will continue to be a cost-effective means of meeting a wide spectrum of societal needs, while capitalizing on the rich diversity among the schools.

The AAMC is heartened to see that this proposal reauthorizes many of these projects which deal with a wide variety of current national currents.

However, it must be noted that these awards seldom reimburse full cost, and absent institutional support, the schools will be hard pressed to find the resources necessary to adequately finance those programs.

We also support the extension of the allowable duration of stay to exchange visitors.

We continue to oppose the extension, however, of the availability of substantial disruption waivers. And that concludes my prepared testimony and obviously we would be delighted to answer any questions that the committee would like to ask us.

[Testimony resumes on p. 215.]

[Dr. Stemmler's prepared statement follows:]



**association of american
medical colleges**

Testimony of
The Association of American Medical Colleges
on
The Health Professions Educational Assistance
and Nurse Training Amendments of 1981
(H.R. 2004)
and
A bill to amend the Immigration and Nationality Act
(H.R. 2056)

I am Dr. Edward J. Stemmler, Dean of the University of Pennsylvania School of Medicine. Dr. Cooper, its President, and I represent the Association of American Medical Colleges (AAMC). Given the time limits, I will restrict my comments to a synopsis of the Association's key concerns. However, I would like to request that the more lengthy explication of our position, to be submitted within the next few days, be entered into the hearing record.

Clearly, the country is currently extremely sensitive to, and deeply engaged in, an examination of the economic constraints within which this nation can operate, both domestically and abroad. Central to this exercise is the question of the appropriate role of the Federal Government in the host of activities

Presented by Edward J. Stemmler, M.D., Dean, University of Pennsylvania, School of Medicine to the House Committee on Energy and Commerce, Subcommittee on Health and the Environment, March 4, 1981.

perceived as necessary to sustain or improve our nation's social condition. Let me summarize why the AAMC believes that Federal participation in the complex enterprise of medical education represents an appropriate as well as an important utilization of Federal resources:

- The quality of health care received by the people of this Nation is ultimately dependent upon the excellence of the education received by medical students.
- The preeminent international stature the United States enjoys in biomedical and behavioral research is directly related to the excellence of the educational institutions in which many of our country's clinical investigators work.
- Past Government investment in these educational programs has yielded a high return in immediate and long range public benefits. While the appropriations for these programs represent only a small fraction of the entire health budget, the achievements stemming from them have significantly improved the performance of the Nation's system of health care.

The reauthorization of the very basic health manpower programs proposed by this bill are now more necessary than ever; medical schools and affiliated teaching hospitals will, in the next few years, be faced with unprecedented reduction of funding on several fronts---from service program , spearheaded by Medicare, from research and research training programs, and even perhaps from the very manpower programs being discussed today.

Student Assistance

Two basic assumptions underly the AAMC's position on the future of student aid programs:

- In view of their high income potential, all but the most impoverished students should ultimately be responsible for financing the major portion of their medical education through either of three mechanisms: direct payment, loan repayment or service payback.
- The cost of obtaining a medical education is becoming almost prohibitive for the average individual. Absent a reasonably comprehensive portfolio of aid programs, the opportunity to secure an M.D. degree will be limited to only those individuals fortunate enough to occupy the upper economic levels of our society.

Therefore, the Association accords student assistance the highest priority in the development of a new statute, advocating that the structure embodied in the renewal legislation:

- Provide an appropriately balanced set of student assistance programs for all qualified students seeking access to a medical education, regardless of their economic status---scholarships as well as guaranteed loans, with and without subsidies.

- Provide manageable debt repayment options in recognition of the economic reality that initiation of repayment of loans is virtually impossible during undergraduate and graduate medical education and a serious hardship during the very early years of practice.
- Decouple programs designed to meet national needs from student aid programs.
- Provide an expanded opportunity for students to repay their indebtedness through loan forgiveness.

The Association is gratified that many elements of the student aid structure envisioned by the proposal before this subcommittee adhere to these principles.

- We commend the modification and expansion of the scholarship program for exceptionally needy students.
- We urge continuation of the Health Professions Student Loan (HPSL) Program.

- We applaud revisions to the Health Education Assistance Loan (HEAL) Program which will hopefully make this "last resort" form of aid somewhat less financially burdensome to students.
- We regret the modification of the loan consolidation provisions in the recently enacted renewal of the Higher Education Act. The Association hopes that the Subcommittee will consider some alternative mechanism to modulate the impact of the usurious interest rates with which a generation of students, unfortunate enough to have to borrow during this time of uncontrollable inflation, will be saddled for a long time.

Institutional Support

The Association's views on institutional support are well known. While currently computed on the basis of student population, it is not primarily a form of student subsidy. Institutional support is utilized for the stabilization of an institution's entire education program, through discretionary interventions at appropriate times and places.

The integrity of a large number of medical schools is seriously threatened today by an unprecedented plethora of destabilizing fiscal forces, whose cumulative impacts could be lethal, an outcome surely not in the public interest. The schools have made commitments to educational programs that hew to joint Federal/institutional objectives with the government, perhaps of higher priority to the former than the latter. Cooperation with government on these public-interest ventures is costly to the schools. For example,

the sponsor does not pay the full costs of the programs and contributes not a whit to the cost of faculty time and effort involved in the planning of these programs, the development of new curriculums, the preparation and processing of applications, etc. Discretionary funds are critically needed: to meet unmet institutional costs to the schools of joining hands with government in a wide variety of activities of great benefit to the whole nation; and especially, to deal with the turbulence induced by vacillations and oscillations in federal commitments. The phase out of institutional support proposed by this bill is of grave concern to our constituents. Institutional support, small as it is, is the only accessible uncommitted money available to most state schools. The true value of these funds exceeds by far their actual magnitude. Most medical school deans view them as the most useful at their disposal: the only resource of funds to meet unexpected contingencies and emergencies, and to develop the new and innovative programs the nation so desperately needs to advance the health of our people.

Other Provisions

While it has commented extensively on other important provisions in its full statement, the Association at this time would simply assert that:

- It believes that the system of special projects grants has proven to be and will continue to be a cost-effective means of meeting a wide spectrum of societal needs while capitalizing upon the rich diversity among the schools. The AAMC is heartened to see that this proposal reauthorizes many

of these projects which deal with a wide variety of current national concerns.

- It questions the necessity and wisdom of a statutory Graduate Medical Educational National Advisory Committee (GMENAC). While continuation of these functions may be desirable, it could be administratively arranged, as either a public or private sector activity.
- It is disappointed by the elimination of new construction authority, obviating the opportunity to replace obsolete facilities or to build space for teaching primary care medicine in ambulatory settings.
- It supports extension of the allowable duration of stay to exchange visitors, but unalterably opposes extension of the availability of substantial disruption waivers.

Thank you. Dr. Cooper and I would be happy to answer any questions you may have.

Mr. WAXMAN. Thank you very much.
Dr. Reese.

STATEMENT OF ERROL REESE, D.D.S.

Dr. REESE. Thank you.

Mr. Chairman and members of the subcommittee, I am Errol Reese, Dean of the Baltimore College of Dental Surgery, with the University of Maryland.

I am pleased to be here to testify on behalf of the American Association of Dental Schools, and as we have submitted our full statement for the record, I will briefly summarize our remarks this afternoon, which will also be in support of the statement that has just been presented.

Currently the most serious difficulty that dental schools and their students confront is that of finding ways to cope with the rapid escalation of the cost of providing and obtaining a dental education.

The yearly educational cost to train a dental student averages over \$24,000 a year, one of the highest of the health professions.

Although tuition charges to students are only a percentage of the total revenue necessary to offset this expense, tuition increases have taken place in both public and private dental schools.

It is obvious that inflation will worsen a serious situation for both the institution and the student. It is important to note that there have been several significant developments within dental schools that have also contributed to institutional expenses.

Schools have expended large sums of money in order to comply with the Federal regulations that are currently prerequisite for institutional support.

In addition, long overdue improvements in the faculty-student ratios have been achieved. Technical equipment, which rapidly becomes outdated in dental school clinics, needs replacement and modification in order to respond adequately to the program needs.

The primary concern of the dental school is to maintain the quality of their programs in a sufficient financial operating basis to maintain this quality.

Elimination of Federal support for dental schools would certainly force further tuition increases. These increases, no matter how necessary, would further increase the serious financial problems that already confront the needy student who wishes to attend dental school.

The current student assistant program, although potentially workable, are underfunded and are accompanied by heavily restrictive regulations which tend to eliminate many students, particularly from the middle income group.

The American Association of Dental Schools believes that the Federal role in helping dental schools and students to address these difficulties is twofold:

First, the Federal Government should supplement other sources of school income, thereby assuring financial stability of the schools so they can provide quality education for the future dentists of the country.

And second, the Federal Government should supply well-designed and adequately funded student assistant programs so that

all students may be assured equal access to dental education, and keep student indebtedness at a manageable level.

We believe it is appropriate for the Federal Government to assume these responsibilities because dental schools have demonstrated exceptional responsiveness in meeting the national health manpower needs.

Indeed, there are 17 States without dental schools.

In summary, without a Federal supplement, it would be difficult in most cases, impossible for schools to generate sufficient income to attain anything resembling financial stability.

It appears unlikely that income from private and state sources can adequately replace the loss of revenue that would be experienced by a severe cut or elimination of institutional support from the Federal Government.

We believe that is essential for the Government to assist the schools with institutional support and minimize their need for tuition increases.

In addition, it is important for student assistance programs to be responsible to the student needs.

Mr. Chairman, this concludes our statement. We are more than happy to respond to any questions.

[Testimony resumes on p. 229.]

[Dr. Reese's statement follows:]

TESTIMONY OF THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS
SUBMITTED TO
U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON ENERGY AND
FOREIGN COMMERCE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
March 4, 1981

Mr. Chairman and members of the Subcommittee, I am Dr. Errol Reese, Dean of the Baltimore College of Dental Surgery of the University of Maryland, speaking on behalf of the American Association of Dental Schools. The American Association of Dental Schools appreciates the opportunity to testify for the record relevant to H.R. 2004, the Health Professions Educational Assistance and Nurse Training Act pending before the House Subcommittee on Health and the Environment. In presenting our views on health manpower, we will first outline some of the problems facing dental schools and their students and then present our views about the appropriate Federal role in addressing these problems.

The most serious difficulty that the dental schools and their students must confront is that of finding ways to cope with the rapid escalation in the cost of providing and obtaining a dental education. For the dental school, the cost of educating a dental student reached a staggering average figure of over \$24,000 per year in the 1979-80 academic year. This yearly educational cost to the institution is certainly one of the highest of the health professions. In that same

academic year the average first year tuition in public dental schools was \$2,370 for residents and \$5,700 for nonresidents. For the first year student attending a private institution the average tuition and fees were \$7,660 and for some it was as high as \$12,000. It is obvious that inflation will worsen a serious situation for both the institution and the student.

However, it is important to note that there have been several significant developments within the dental schools that have also contributed to institutional expense. Schools have expended large sums of money in order to comply with Federal requirements that are currently prerequisite for institutional support. In addition, effective and long overdue improvements in faculty-student ratios have been achieved. Technical equipment which rapidly becomes outmoded in highly utilized dental school clinics have needed replacement and modification in order to respond adequately to new program needs.

The primary concern of the dental schools is to maintain the quality of their programs and remain financially viable. In a survey completed early last year by the American Association of Dental Schools, the schools that are receiving capitation grants were asked to specify the

actions they expected to take in order to accommodate the reduced level of funding in fiscal year 1979. Without Federal support dental schools in general would have to obtain replacement funds to support up to 57 percent of faculty and staff salaries. For public schools it is becoming more difficult each year to obtain the adequate funds from the state to continue quality programs. Private dental schools would have to obtain sufficient replacement funds for almost 62 percent of their faculty and staff salaries. One school anticipated the closing of the school library. All were concerned that the actions they were taking were making it increasingly difficult to recruit and retain competent clinical faculty in the years ahead.

In addition, almost three fifths of the schools responding to the survey planned an immediate increase in tuition and fees to compensate in part for the reduction in funds. Some institutions reported that they would be forced to curtail or eliminate various student programs, including programs aimed at the recruitment and retention of minority students. Increases in tuition, no matter how necessary, would certainly exacerbate the serious financial problems that already confront the needy student who wishes to attend dental school. Current student assistance programs, although potentially workable, are underfunded and are accompanied by heavily restrictive regulations which tend to eliminate many students from the middle income group.

The Health Educational Assistance Loan (HEAL) program that was designed to assist students in these circumstances is not available at all to students in schools that have opted to forego capitation. Those students who are able to avail themselves of the HEAL program find that their original indebtedness is greatly inflated by the comparatively high interest rate provisions. To this educational indebtedness, the newly graduated dentists who wish to enter practice upon completion of their dental education must immediately incur large additional debts to establish their practices. Repayment of educational and practice indebtedness begins during a period in their careers when their earnings are their lowest.

What then is the Federal role in helping schools and students to address these serious difficulties? We believe this role is two-fold: (1) the Federal Government should supplement other sources of school income thereby assuring the fiscal stability of the schools so they can provide quality education for the future dentists of the country; and (2) the Federal Government should provide well designed and adequately funded student assistance programs, so that all students may be assured equal access to a dental education, and keep student indebtedness at a manageable level. We believe it is appropriate that the Federal Government assume these responsibilities because dental schools

have demonstrated exceptional responsiveness in meeting national health manpower needs. Indeed, there are seventeen states without dental schools and these states must rely upon the schools located in other states for their supply of dentists.

Without a federal supplement it will be difficult and in some cases impossible for schools to generate sufficient income to attain anything resembling fiscal stability. It appears unlikely that income from private and state sources can adequately replace loss of revenues that would be experienced by a severe cut or elimination of institutional support from the Federal Government. We believe that it is essential for the Federal Government to assist the schools through institutional support to minimize their need for tuition increases.

Also, it is important for student assistance programs to be responsive to student needs rather than having the total cost of education the responsibility of the student because of the potentially high income of the health professions student after graduation.

Institutional Support

The Association endorses the continuation of modified institutional support for health professions schools as an important resource in maintaining fiscal stability for these institutions. We therefore

support the philosophy in H.R. 2004 sponsored by you, Mr. Chairman, of maintaining a viable realistic institutional support program. However, we are concerned that, with the exception of certain modifications, H.R. 2004 essentially provides an extension for current institutional support authority. We believe that the assurances that dental schools must meet in order to receive institutional support under the current authority are either obsolete or unnecessarily burdensome. Therefore, an extension of an institutional support program with these same requirements would be undesirable, further escalate the cost of dental education, and provide more dental graduates than are needed to meet the demand for dental services. The preferred mechanism would be institutional support with no assurances because this would allow schools to direct funds into their own particular curriculum and faculty ordinarily developed with the needs of the community and region in mind. At minimum, any assurances tied to institutional support must be reasonable, flexible and not overly burdensome.

We emphasize that these assurances must be within the context of institutional support. We do not think that these objectives can be realized through project grant authorities because special project grants are targeted authorities carrying a forward commitment for operating resources and do not provide basic consistent financial assistance to the dental schools.

Student Assistance

The American Association of Dental Schools believes that the thrust of H.R. 2004 in incrementally improving the features of a working system of student assistance to health professions students is a sound approach to the complexities of student financial assistance problems. As included in your bill, we fully support the extension of the health professions direct loan program because we believe that it is a reasonable and responsible method of assuring financial assistance to students that need support. While we believe that the improvements suggested in H.R. 2004 are well conceived, we suggest that additional modifications would more adequately address the problem.

Interest subsidies for Health Education Assistance Loan (HEAL) recipients, and extended repayment period for Health Professions Students Loans (HPSL) would relieve some of the burdens of the already seriously indebted dental students. In addition, H.R. 2004 would effect a much needed graduated repayment provision which we strongly endorse. Such a provision would allow young practitioners to repay their indebtedness in keeping with the growth of their practices.

The Association believes that an expanded loan repayment program is appropriate. A loan repayment program, if adequately funded, is much more effective in meeting the needs of shortage areas than are other

need-targeted programs. In our opinion, graduates who avail themselves of loan repayment would more likely remain in an area that needs dentists than an individual who make a commitment to serve in a need area as a precondition to receipt of a loan or scholarship early in his or her dental education.

Finally, the Exceptional Financial Need Scholarship program should be retained. That program has been an important resource for dental students who otherwise would be unable to obtain a dental education. Unfortunately, appropriations for this program have been low and only one or two scholarships have been available to each dental school.

Special Projects

The Association supports the proposal to continue some existing project grant authorities. In particular, we believe that federal support should continue to be directed to General Practice Residency programs in dental schools and in accredited programs in hospitals and other appropriate entities.

In addition, we suggest new grant authorities for curriculum development in health care economics, continuing education projects and projects to demonstrate means of reducing the costs of health professions education and curriculum development.

The Association recommends adding authority providing special project funding to (1) develop new admission policies, procedures, and criteria for increasing enrollment of students who are committed to serve underserved populations, who are residents of underserved areas, or who are likely to enter general practice; (2) plan, develop, and operate, or maintain clinical education programs including preceptorships and interdisciplinary training in underserved areas or in health manpower shortage areas; or (3) plan, develop, and operate, or maintain programs to provide individuals who meet or plan to meet the needs of underserved populations, education including continuing education and training related to the delivery of health care to medically underserved populations.

The Association also believes that authority providing for grants for preventive dentistry training would be appropriate.

We suggest special project grants in nutrition, geriatrics, rehabilitation and containment of health care costs; as well as providing funds to schools to increase the participation of women in health careers; and providing for research and demonstration projects. All of these functions are of great importance and these project grant authorities would significantly further the current efforts of the dental schools in these directions.

Construction Grants

The Association supports the provision in H.R. 2004 repealing the requirements imposed on previous grantees for increased enrollment as a condition for receiving construction grants, however, we do not believe that total elimination of construction grant authority is advisable. Construction grant authority should be available to assist in the replacement of equipment and to renovate outmoded teaching facilities. Although most dental schools have been built, replaced, or renovated within the past fifteen years, many need to replace equipment and to modernize educational facilities to keep pace with changing technology. Unlike medical schools which ordinarily have access to hospitals and clinical equipment, dental schools are largely self-contained and must provide their own high cost equipment. Because this equipment is utilized daily it becomes worn and needs to be replaced in a short period of time.

Financial Distress

In our judgment, financial distress authority should adequately reflect the magnitude of need that could result if institutions face unexpected financial problems. We therefore support extension of existing authority for financial distress grants with the further recommendation that

authorization levels be high enough to anticipate adequately the potential increases in the number of dental schools that might experience financial distress in the near future.

National Health Service Corps Scholarships

The Association supports the basic concept of phasing down the National Health Service Corps scholarship program to a level that is consistent with realistic shortage area requirements. We believe that a program primarily administered at the state level would likely be more responsive to the real problems of meeting the needs of underserved populations. The Association thinks that continued phased-down support for National Health Service Corps Scholarship authority is appropriate, but should be retained until a shift of such responsibility can be assumed by the states. Continuation of the NHSC scholarship provisions should not be considered a general student assistance provision and must be coordinated to the needs for career NHSC dentists in state designated shortage areas. We are particularly concerned about recent trends to expand the National Health Service Corps Scholarship program at the expense of other student assistance such as the Health Professions Student Loan program, and Exceptional Financial Need Scholarship program. We do not support the concept that the NHSC is the principle source to effect a better distribution of health manpower. Programs such as the

National Health Professions Placement Network are realistic methods to match community need and health manpower availability. NHSC should be the resource available to need areas that have no other way to alleviate shortage of health manpower. In short, we believe that NHSC scholarships should be limited to those dental students that intend to serve in the National Health Service Corps as a career and the number supported should not exceed the number expected to be needed in the year of graduation and available for service.

Mr. Chairman, we appreciate the opportunity to make these comments. If the American Association of Dental Schools can provide any assistance to you, the members of the Subcommittee or the staff, please do not hesitate to contact us.

Mr. WAXMAN. Thank you very much.

As you may well be aware, we have been summoned to the House floor for a vote. Let me declare a recess for so long as it will take for us to respond to the vote and return and continue the meeting.

[Brief recess.]

Ms. MIKULSKI [presiding]. We expect Mr. Waxman to return. He had to vote, No. 1, and No. 2, the Democratic caucus of the full committee is meeting on our budget, so he had to be there to defend his rather modest increase.

Dr. Cohen, I believe that you were next to testify, and the committee welcomes you and looks forward to your testimony.

STATEMENT OF BENJAMIN COHEN, D.O.

Dr. COHEN. Madam Chairman, I am the dean of the College of Medicine of Dentistry of the New Jersey School of Osteopathic Medicine, and also professor of pediatrics at that institution.

I am speaking today on behalf of the American Association of Colleges of Osteopathic Medicine.

The commitment to primary care and to the redress of geographic and specialty imbalances is not new to the osteopathic medical education profession and practice.

Osteopathic medicine has historically emphasized the preparation of primary care practitioners for community-based service.

Of the more than 17,000 osteopathic physicians in the United States today, approximately 90 percent are engaged in the delivery of primary care. Those 90 percent are seeing approximately 25 million Americans each year.

Moreover, osteopathic physicians tend to settle in small communities with over 50 percent settling in communities of 50,000 or less; and of that, 50 percent of those are in communities of 25,000 or less.

In short, osteopathic medicine has had a proven record of responsiveness to national health care needs even before they were articulated in terms of Federal policy.

Many of our successes can be directly attributed to the impact of Public Law 94-484, because lacking the impetus of Federal assistance it is doubtful that our colleges could have undertaken the dramatic development and expansion efforts necessary to address the acute geographical and specialty maldistribution problems.

However, we have watched with growing frustration repeated attempts to erode or eradicate precisely that Federal support which has made possible many of the most significant and effective responses of the health professions educational community to national health priorities.

We thus are most appreciative of the commitment embodied in H.R. 2004 to retain a comprehensive program of Federal participation in health professions education.

Osteopathic institutions are somewhat different. Our colleges are not megamillion dollar institutions. They lack substantive foundation support. They are not research oriented. They are service oriented. Therefore, the colleges of osteopathic medicine don't have the ability to share in the rich overhead support and other substantive measures that the traditional schools have always had.

Because of this, we are gratified that H.R. 2004 proposes to continue institutional support authority. This flexible nonprogrammatic grant mechanism has helped insure the continuity of quality and responsiveness to the Federal goals of health professions education.

If our schools do not receive institutional support, some of them will be in dire trouble. Right now most of the osteopathic schools are private institutions. The average tuition at those institutions is \$10,000 plus. If institutional support is dropped, the tuition will have to go up, and I am afraid, *de facto*, we will be asking the student body who will graduate with a great debt to automatically seek those kinds of practice where the remuneration will be higher and that will not be primary care.

Our association is very supportive of the continuance of student assistance. Federally supported student assistance programs have been highly successful mechanisms for assuring the availability of adequate practitioner supply while permitting the students to enter the health manpower work force regardless of their economic status.

During the academic year 1979 to 1980, one third of all osteopathic students participated in Federal scholarships, and more than 90 percent were recipients of federally guaranteed or subsidized loans.

The National Health Corps scholarship program has been extremely effective in channeling students into geographic and specialty shortage areas while minimizing economic discrimination.

We are particularly pleased to note the reauthorization of the health profession student loan program. This popular program is the only direct loan program targeted specifically at health professions students.

In addition, while we support the postdoctoral programs of Public Law 94-484, we'd like to respectfully point out to this committee that we think the role models ought to start at the undergraduate level, and in osteopathic institutions we want most of our graduates to go into primary care. We need institutional support at the undergraduate level, the predoctoral level, for family medicine.

One additional request that our association has is that we are appalled by the magnitude of the reduction in the Health Resources Administration budget. What seemed to some to be the Cadillac or a Continental budget was in reality a Ford or a Chevy budget. The administration is now asking that that be a minibike, without fuel, and asking the people to pedal up to Mount St. Helens to look at the volcano that is about to erupt.

Ms. MIKULSKI. You forgot to say they don't have crash helmets on, either.

Dr. COHEN. We are appalled at this magnitude. There is no other Federal agency capable of duplicating HRA's expertise; and most important of all, the pending budget proposal approved by Congress will make it impossible to implement any authorizing legislation relative to health professions education which this subcommittee may recommend.

In summary, in spite of all the other woes that this Nation has, we are one of the healthiest nations in the world. By and large, Congress and the taxpayers were responsible because they nour-

ished the sciences and medical training. If today Congress starves the system, the origin, the mother of medical education and health care systems, tomorrow's health of this Nation will suffer irreparable damage.

We therefore welcome the attempt embodied by H.R. 2004 to preserve the comprehensive and continuing Federal presence in training of the individuals who will deliver health care to the American people for many years to come.

Thank you.

[Testimony resumes on p. 240.]

[Dr. Cohen's prepared statement follows:]

Testimony of the

AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

INTRODUCTION

Throughout its history the osteopathic profession, represented by more than 17,000 practitioners in the United States, has worked to provide quality primary medical care. Approximately 90 percent of all osteopathic physicians are currently engaged in the delivery of primary care services, striking evidence of the significant contribution the osteopathic profession has made to meeting the national goal of making medical care available to all Americans.

In a similar manner osteopathic physicians have been instrumental in assuring access to care for persons living in geographical areas experiencing chronic health manpower shortages. The traditional emphasis of osteopathic medicine on family/general practice in the medically underserved regions of this nation is perhaps the only systematic effort in the private sector toward this goal ever undertaken. The osteopathic profession currently deploys 67 percent of its manpower in the nation's largest and smallest communities, the areas of greatest need: 50.5 percent in communities of 50,000 or less and 16.9 percent in communities of 500,000 or more.

Another area of national concern — the rising cost of health services — has likewise been a matter of importance to osteopathic physicians in terms of their practice patterns and hospital utilization. The profession's continuing emphasis on community-based ambulatory care as the preferred locus of treatment has over the years perpetuated a model of efficiency and cost-effectiveness.

In short, osteopathic medicine has had a proven record of responsiveness to national health care needs and goals long before they were articulated in terms of federal policy, and over the years has developed considerable expertise in assuring all Americans access to timely, pertinent, quality primary health care.

Many of our successes can be directly attributed to the impact of P.L. 94-484. Lacking the impetus of federal assistance, it is doubtful that our colleges could have embarked upon the dramatic development and expansion efforts necessary to address the acute geographical and specialty maldistribution problems which still characterize health care in this country. We have watched with growing frustration repeated attempts to erode or eradicate precisely that federal support which has made possible many of the most significant and effective responses by the health professions educational community to national health priorities.

It would be disingenuous of us to ignore the straitened nature of the federal budget now under consideration, or to minimize the importance of exercising selective fiscal restraint in setting federal expenditures for health professions education, as for all other aspects of the economy. However, opponents of such support are equally disingenuous in supposing that by taking the proverbial meat-ax to those programs currently funded under P.L. 94-484 significant and in some cases irreversible damage will not be done to the scope and quality of training programs. The false economy of an indiscriminate approach to fixing programs and authorizations is all too readily apparent. Not only will the functional

capabilities of the health professions schools be seriously impaired, but as tuitions are forced upward to compensate for lost federal funding, students will be driven even more deeply into debts which they will have to meet through higher patient charges. Thus, while the short-term impact of a massive retrenchment in federal assistance would disadvantage educational programs and facilities, the long-range consequences are more far-reaching, potentially affecting every health care consumer by pushing the cost of services well beyond current limits.

The following remarks highlight those programmatic and conceptual areas of particular importance to the osteopathic educational community: student financial assistance, institutional support, minority education, faculty development, and primary care training at both predoctoral and postdoctoral levels. Within the confines of this statement we have chosen not to address other provisions with which we concur, among them facilities renovation authorities and continued support for Area Health Education Centers. Nonetheless, we are fully supportive of these programs, as of the scope of H.R. 2004 as a whole, and we will be pleased to expand our remarks in any of these areas as the subcommittee may request.

I. STUDENT ASSISTANCE

Federally-supported student assistance programs have been highly successful mechanisms for assuring the availability of an adequate practitioner supply, while permitting students to enter the health manpower work force regardless of economic status. During the academic year 1979-80 nearly one-third of all osteopathic students participated in federal scholarship programs, and more than 90 percent were recipients of federally guaranteed or subsidized loans. Without such support student debt loads - and with them, health care costs - will skyrocket, and economics rather than talent will determine the composition of the student pool, to the detriment of both quality and equality of opportunity.

We advocate a pluralistic mix of scholarship, subsidized loan, and conventional loan programs of the type recommended in H.R. 2004, and are particularly supportive of the following initiatives.

A. National Health Service Corps; NHSC Scholarship Program

The National Health Service Corps and its scholarship program have been extremely effective in channeling students into geographical and specialty shortage areas while minimizing economic discrimination. Consistent with osteopathic medicine's traditional emphasis on community-based practice, a disproportionately large number of osteopathic students are currently recipients of NHSC scholarships or practicing members of the Corps; and we look to continuation of the NHSC scholarship program as a student support mechanism singularly appropriate to the practice pattern of the majority of osteopathic physicians.

However, in continuing the three-year limitation on deferrals for graduate medical students under Section 752(b)(5)(A), H.R. 2004 unwittingly perpetuates a mechanism which discriminates against osteopathic medical education. All osteopathic students are required to undertake a one-year rotating internship in addition to any residency program they may elect to pursue, thus effectively extending their graduate training to four years rather than the three common to allopathic education. The need to accommodate this unique feature of the osteopathic educational model was recently addressed through the addition of language providing for Secretarial discretion in granting deferrals exceeding three years under "The Nurse Training Amendments of 1979," P.L. 96-76, Section 202, and in Section 205(d)(1)(B) of this bill, which extends to four years the deferral option under the HEAL program. We trust that this problem can be resolved in the language of the new law rather than through post facto amendment.

B. Exceptional Financial Need Scholarships

If recruitment and retention of qualified students regardless of economic status are to register more than token gains, the EFN program must receive a realistic commitment of federal funds. We are pleased to note the inclusion of an expanded EFN program at an authorization level capable of providing adequate assistance to both needy first- and second- year students.

C. Health Professions Student Loan Program

We are highly supportive of the retention of the Health Professions Student Loan Program, the most demonstrably successful health-oriented federal loan program now in operation. This program, the most popular of the student assistance options under current law, has just begun to recapitalize on the basis of loan repayments, and early indications point to an unusually low default rate (less than 2 percent). Even without the appropriation of new monies the program is in a position to be self-supporting through the rollover of incoming repayments for new loans. The perpetuation of proven loan programs such as this one must be viewed as a priority if freedom of career choice regardless of economic status is to be assured.

D. Health Education Assistance Loan Program

Continuation of the HEAL program at borrowing ceilings consistent with actual educational cost is welcomed, as is expansion of the deferral option to four years as a mechanism for accommodating the osteopathic internship. Given current rates of interest on the open market, we predict greatly expanded utilization of this program by health professions students in the coming years.

II. INSTITUTIONAL SUPPORT

In the past Congress has provided support to institutions educating health professionals to encourage the production of additional manpower to meet national needs. These flexible, nonprogrammatic funds have been used to insure the continuity, quality, and responsiveness of health professions education to federal goals, and have been instrumental in holding tuition costs to the lowest possible level consistent with the maintenance of institutional viability. This last point is particularly important, for higher tuition will inevitably lead to higher patient care costs when students enter practice and begin to repay their educational debts. Moreover, significant tuition increases will effectively preclude disadvantaged students from entering careers in the health professions, thereby imposing discriminatory economic constraints on the composition of the practitioner pool.

With respect to osteopathic medical education there are other problems as well. Several new osteopathic colleges have arisen in response to the discrete demand for distinctively osteopathic care and the general demand for additional primary care physicians. Many of these new schools depend on institutional support to offset some portion of the unusually heavy expenses incurred during the developmental phase of an institution's life. The established osteopathic colleges are also uniquely in need of this form of assistance, for unlike most health professions schools, the majority of them are not attached to large educational complexes whose shared resources help keep operational costs to a minimum. Likewise, because our schools concentrate on preparing primary care physicians to enter practice at the earliest opportunity, their research component — and its attendant benefits relative to the acquisition of permanent facilities, faculty, and overhead offsets — is necessarily limited. These colleges rely heavily on the flexible nature of institutional support to assist them in initiating creative programs in nutrition education, patient education, remote-site training, and similar educational activities consistent with federal goals.

Our schools have been actively seeking alternative sources of income to counterbalance the expected reorientation of federal priorities away from this type of support. However, this process has been slow and, given the critical state of the American economy, too often without tangible issue. Additional time and a continued, if reduced, federal commitment to institutional funding are needed if the health professions schools are to free themselves of federal dependency in this area. We believe institutional core support should be continued, but we also realize that Congress may wish to effect significant change in both the direction and scope of such support. We therefore recommend that if the current effort is phased out as proposed in H.R. 2004, it should be replaced with a program which provides support to colleges having a proven record of producing primary care practitioners, and which encourages schools not having such a record to revise their curricula accordingly. We stand ready to work with this Subcommittee to develop a mechanism which will assure essential core support

mechanism which will assure needed core support to the nation's health professions educational institutions while simultaneously reinforcing the goal of educating more primary care practitioners to serve the needs of the American people.

III. SPECIAL PROJECTS

A. Predoctoral Training

We are pleased to note in Part D continuation of the various special project grant authorities which have been so useful to our schools in developing and augmenting their programs to meet national needs. However, we are deeply dismayed that H.R. 2004 continues to reflect the virtually exclusive preoccupation of P.L. 94-484 with postdoctoral primary care training while providing no perceptible recognition or support for predoctoral education. The osteopathic academic model is unique in that students receive the major portion of their primary care education as undergraduates, and the curriculum is largely geared to this level. By limiting the programs authorized under Sections 218 and 219 to postdoctoral activities the bill in effect penalizes osteopathic colleges for past successes in training primary care physicians under a different educational system.

In our view predoctoral education should be equally a matter of federal concern, for it is here (as the unusually large number of osteopathic physicians in primary care practice clearly demonstrates) that there exists the greatest potential to attract significant numbers of students to first-contact care and retain them as practitioners. We urge the Subcommittee to consider making specific statutory provision for predoctoral primary care programs, in addition to continuing existing support for internship and residency training. We would like to suggest three areas in which modest amendment of existing law would generate immense benefits both for predoctoral medical education and, ultimately, for the quality and availability of primary care services nationwide.

1. Faculty Development - The new primary care faculty development component under Section 218, and the proposed continuation of a similar provision under Section 786, are most welcome, for in the past federally-supported faculty development activities have been minimal. A technical amendment expanding the teaching locus for individuals trained under these authorities beyond the specified postdoctoral training programs in general internal medicine/general pediatrics and family medicine (i.e., to undergraduate educational programs) will provide a greatly-needed addition to the faculty pool for medical colleges at no additional cost.

2. Remote-Site Clinical Training - While we endorse continuation of the remote-site requirement under Section 770, we are disappointed that H.R. 2004 fails to include support for clinical training. One factor responsible for our marked success in attracting and retaining practitioners in underserved communities has been the exposure of students early and repeatedly during their

clinical training to practice in remote-site ambulatory settings, yet little federal support has been available for this training modality. While remote-site training is unquestionably a cost-effective activity both in terms of providing direct services in shortage areas and developing practitioners interested in making a long term career commitment to this type of practice, it will require federal assistance if it is to continue and grow.

3. Curriculum Development - Curriculum development activities supported under Section 788(d) have proved perhaps the single most cost-beneficial program under P.L. 94-484, assuring the continued flexibility and relevance of medical education for a relatively small federal investment while helping the health professions schools expand their academic capabilities in areas relevant to national needs. Since its inception the program has generated many innovative advances in medical education and practice, despite minimal appropriations: the \$8.5 million appropriated during FY1981 for both section 788(c) and (d) barely accommodates continuation grants, and provides no support for new projects however timely or significant. Rather than continuing to tie the funding of 788 (d) activities to an umbrella authorization embracing start-up assistance and interdisciplinary training support as well in a perpetual zero-sum game, we urge the Subcommittee to create a separate authority for curriculum development, as has been done for financial distress grants (Section 788(b) of current law). In so doing this valuable program can at last achieve the solid funding base it requires to maximize its impact.

B. Minority Enrollment

We wholeheartedly endorse the increased scope and authorization for disadvantaged assistance under Section 220. Although the colleges of osteopathic medicine have been consistently supportive of special efforts directed toward disadvantaged students, the limited funding made available under this authority in the past has been insufficient to create the desired effect. This stricture is especially severe in the case of programs targeted at the attraction and retention of minority students. Particularly in the case of small schools lacking affiliation with a large university system, the availability of faculty to provide the necessary counseling, remedial, and socialization support cannot be guaranteed without increased access to the requisite funding. In the absence of one or more full-time staff members committed solely to overseeing the various aspects of the proposed program, responsibility for operating it will devolve upon staff members already overworked, with predictably dissatisfying results.

Despite chronic underfunding, programs such as the Health Careers Opportunities Program (HCOP) have managed to produce impressive results. Through a HCOP grant the American Association of Colleges of Osteopathic Medicine has established an Office of Special Opportunities (OSO) to increase the representation of ethnic disadvantaged students in colleges of osteopathic medicine. Administered in cooperation with a consortium composed of the fifteen colleges

of osteopathic medicine, the program provides a variety of services to individual schools to stimulate local initiatives such as undergraduate recruitment, summer preceptorships, pre- and post-admission academic reinforcement and peer counseling. Through the OSO a national osteopathic career information service has been made available to students, counselors, and advisors at both secondary and predoctoral levels.

A recent review of applicant and enrollment statistics for our schools indicates a significant positive demographic shift, attributable in large measure to HCOP's role in assisting osteopathic institutions to recruit and retain minority students. The percentage of minority applicants to colleges of osteopathic medicine has risen from 4.5 % in 1975 to more than 9% in 1981. First-year enrollments of minorities have likewise increased, from 5.7% in 1975 to 6.8% in 1980. The HCOP approach clearly works; but if minority recruitment and retention activities are to register more than token gains, the federal commitment must be meaningful augmented as proposed.

IV. MISCELLANEOUS ISSUES

A. National Advisory Council on Graduate Medical Education

We are pleased to see a continuation authority for this body, which has begun to issue analytical tools and paradigms of considerable utility in estimating current health manpower shortages and establishing the parameters and directions of future federally-supported health profession programs. However, we are deeply disturbed by repeated references to the allopathic Coordinating Council on Medical Education (as an ex officio member of the Advisory Committee (Section 712(a)(1)(A)), as a consultant to the Advisory Committee (Section 712(c)(1), and as a specified contracting authority (Section 712(c)(2)) without equal attention in statutory language to the corresponding osteopathic body. Of particular concern is designation of the Chairman of the CCME as a ex officio member of the Advisory Committee without similar provision being made for a representative of osteopathic medical education to serve in the same capacity. We trust that this de facto discrimination against the osteopathic educational community is inadvertent, and that the bill will be amended to assure parity for both medical professions at this policy level.

B. Health Resources Administration Budgetary Concerns

Finally, we are compelled to raise a subsidiary issue which needs to be addressed with the context of H.R. 2004, namely the Administration's proposed reduction by more than 80% in Health Resources Administration personnel under the President's FY1982 budget proposal.

We are appalled at the magnitude of the contemplated action, which will render HRA effectively dysfunctional. There is quite simply no other federal agency capable of duplicating HRA's expertise in administering health manpower

education programs, or its knowledge of the needs and capabilities of the various participants in those programs. Nor is there an alternate locus within the Department of Health and Human Services for undertaking HRA's invaluable informational and technical assistance functions, which have been systematically and fruitfully utilized over the years not only by the health professions schools but by Congress and the Administration as well.

Most important of all, if approved by Congress the pending budget proposal will make it impossible to implement any authorizing legislation relative to health professions education which this Subcommittee may recommend, however worthy. We therefore urge you to give this matter your full and immediate attention, and to impress both upon your Congressional colleagues and Administration representatives the wholly untenable nature of such a decision.

Like our colleagues in the health professions education community, the colleges of osteopathic medicine are deeply disturbed at what is emerging as a "meat-ax" mentality on the part of some members of Congress and the Administration with regard to continued federal participation in health manpower training programs. The indiscriminate erasure of many programs, and the crippling by token funding of others, will unquestionably result in significant and in some cases irreversible damage to the scope and quality of health professions education. We therefore welcome the attempt in H.R. 2004 to preserve a comprehensive and continuing federal presence in training the individuals who will deliver health care to the American people for many years to come, and we appreciate this opportunity to lay our views before you. We will be happy to answer any questions relative to our testimony.

Mr. WAXMAN. Thank you very much for your testimony.

Let me start with you, Dr. Stemmler. I was curious about one comment you made. You thought we ought to decouple the National Service Corps from student aid or scholarship. What did you mean by that?

Dr. STEMMLER. Well, we are watching the growth of an organization within Government for providing physician services, the National Health Service Corps. This Corps, of course, is growing at a very rapid rate, and we just have to look at the budget authorization figures proposed under this current bill to be struck by the escalation of those numbers. Of course, that Corps is growing by being supplied by a scholarship program which has been its feeder source.

Our association feels that there is an inappropriate linkage between the Corps which is designed to provide service and true financial aid which is to provide assistance which makes medical education accessible to all people. We would like to see that the Corps not grow further and that funds that might thereby be freed be diverted more appropriately into true financial aid for our students.

Mr. WAXMAN. What would true financial aid be?

Dr. STEMMLER. Through loans.

Mr. WAXMAN. You don't believe the Federal Government ought to provide scholarship money whatsoever?

Dr. STEMMLER. I wouldn't go so far as to say that in the absolute, because there are certain individuals who are in such extraordinary need. As a basic principle we support the concept that medical students ought to defray a significant portion of the cost of their own education.

Mr. WAXMAN. Would you take the same attitude about military scholarships?

Dr. STEMMLER. There is a difference between the National Health Service Corps and the armed services although they use the same kind of financial device. I say, and you know, that there may very well be a strong national need for physicians in the military, and if the way to providing staffing is through a scholarship device, then that may for the time being be appropriate.

What I am saying is that the provision of health services to civilians by an organization within Government appears now to be no longer as necessary as it was thought to be in previous years.

Mr. WAXMAN. Do you feel it's necessary for us to say to medical students, "We will give you a scholarship if you promise to serve as a physician in the military," but we don't need to say to students who would like to serve in underserved areas, "We will give you a scholarship if you promise to serve in underserved areas"? And if you do reach that conclusion, is it because we have taken care of that need?

Dr. STEMMLER. No, I would not say we have taken care of that need entirely. Testimony has been presented here by many different groups that there are some major changes occurring and that past and present efforts are providing solutions regarding access to health services. What I am focusing on is whether we continue to have a need to expand a corps within Federal Government, now

that the availability of physicians through the private sector appears to be in that direction of solving access problems.

Mr. WAXMAN. Will that trend take care of the military physician problem?

Dr. STEMMLER. Apparently that has not happened, and I cannot speak in any detail to that point, but I think others can. I believe that the military continues to need physicians.

Mr. WAXMAN. Have you been present for the whole hearing today?

Dr. STEMMLER. Most of it, yes, sir.

Mr. WAXMAN. We had testimony earlier that despite the surplus of doctors as projected by GMENAC, the needs are not going to be taken care of for maybe 12 to 14 million Americans who are structurally underserved. Do you disagree with that?

Dr. STEMMLER. As a matter of fact, I was struck by that testimony, and don't differ in principle with it except that I personally believe there is a core of people who chose not to avail themselves of health services, and that they may be the real structurally underserved. I am not sure what that percentage of the population they constitute.

I think there is evidence from a study conducted by the University of Chicago, funded by the Robert Wood Johnson Foundation, of a very high percentage of people who are satisfied with their access to health care.

Mr. WAXMAN. The administration is proposing to zero out the financially needy program which is a scholarship for the first year medical school education.

I believe they are also suggesting we not give any more scholarship money for the National Health Service Corps. Do you feel the medical schools will be capable of meeting the needs for financially needy students who are going to require scholarship assistance, as well as perhaps loan assistance?

Dr. STEMMLER. I think the national policy ought to be to provide access to medical education for all people who are qualified, and if that is the general policy, then it seems to me we have got to offer programs at the Federal level which enable individuals, who find it very difficult to even consider studying medicine, to know it is possible.

I think the exceptional need scholarship program deals with that. It has some defects that might be adjusted in the current legislation. I think the idea of providing help for more than 1 year is helpful, and we support that.

Mr. WAXMAN. Last year the AAMC provided for subsidizing by the Government of the low-interest rate for those students who received that loan, that subsidized loan, that would then be in a pool subject to being drafted to go serve in underserved areas.

Do you still support that idea this year?

Dr. STEMMLER. Well, as a matter of principle, our association would prefer not to support a quid pro quo that would in a sense endenture students for future service.

On the other hand, I think the testimony last year was related to the bills that we had in hand that we had to speak to. Given the choices open at that time, our association felt that the service contingent loan program was preferred to the more undesirable

choices that then forced students into high interest borrowings, which we thought had unpredictable outcomes.

Mr. WAXMAN. Should we subsidize loans for medical students?

Dr. STEMMLER. I think financial aid at reasonable cost ought to be available to medical students, and it is a matter of judgment as to what is reasonable. Loans ought to be subsidized so that students who incur major indebtedness are assured some freedom of career choice. Let's consider a loan of \$40,000, since that amount was used earlier. We can project that under the current interest rates, a student during a 10-year period after finishing his graduate training would have to pay back something like \$190,000.

What we don't know as a national policy consideration is what we are bequeathing to our successors, our heirs, in terms of that kind of a policy. My own view is that, in the long haul, it might be less expensive for the Government to provide those interest subsidies so that students who do borrow can manage those debts within reason.

Mr. WAXMAN. Do you think the level of fees charged for health care services are in any way affected or especially affected particularly by the amount of the loan that a physician or a dentist or osteopath carries?

Dr. STEMMLER. We don't know the answer to that question. As a practical fellow, I predict that, if students carry a repayment obligation for indebtedness for education that might cost \$1,250 a month, in some way that is going to be garnered through the services provided, if it's possible to do so in a future economic system.

Mr. WAXMAN. Do you think with their loans paid off, they will lower their fees?

Dr. STEMMLER. I think they are going to be responding to whatever market conditions are present at that time. On the other hand, there is no question about what they will do if they carry the debt burden.

Mr. WAXMAN. Some experts have suggested the elimination of Federal enrollment requirements. What are your feelings about that?

Dr. STEMMLER. It's interesting, because the policy of withdrawing institutional support while, at the same time, eliminating the maintenance of enrollment, requirement, gives mixed signals and may have mixed effects.

On the one hand, the appropriate way to deal with a loss of support may be to increase enrollment, and schools, on the other hand, which may want to reduce enrollment because of many factors, including responses to health policy, may find it very difficult to do so.

Mr. WAXMAN. Dr. Reese.

Dr. REESE. Could I first comment about some of the questions you have presented?

First of all, I would concur, and I think our association would concur, with everything that's just been said relative to the National Health Service Corps scholarship program.

We do have some concern that there may be a trend toward lumping all of our scholarship money into that area. Possibly origi-

nally the concept was to help alleviate maldistribution problems, as well as provide scholarship funds.

Last year approximately 360 new scholarships were available to dental students out of 6,000 first year dental students in the Nation.

At that point I will differ somewhat from the previous comments about student loans, specifically because of the uniqueness of the type of education that dental education happens to be, and what a student is confronted with. First of all, let me point out that at the present time, over 50 percent of the dental students enrolled in schools, their parents earn less than \$30,000 a year. The average tuition is in fact in public schools around \$2,500 and around \$6,000 for nonresidents in those State schools. In private schools it runs from \$7,000 to an excess of \$12,000.

As opposed to medical education, a dental student is faced with purchasing between \$3,000 and \$5,000 worth of instruments in the first year of his education. He utilizes them during his entire educational period and can utilize them in his practice.

Approximately 77 percent of the dental students in the Nation today are in need of financial support. If you have a group of students whose background, whose family is around the income level I have just indicated to you, you can see why.

Therefore, we hope, and I would plead for all the dental students, that as the State and as the private schools increase their tuition, that loan moneys be made available at a decent rate, be provided in such a way that payment could be spread out so that they must not be encumbered, particularly during dental school, and then some graduated payment method be established after they begin practice.

You also may be interested to note that dental students, as they graduate from dental school, are faced with a tremendous start-up cost. The capital outlay to establish a dental practice is the greatest of any profession.

At the same time, current figures indicate that after 3 years of practice, their gross income is \$26,000. So we are faced with a triple-barrel situation. The cost is greater, the cost of establishing a practice is greater, and income potential is much less now.

An obvious question is, does this have an impact on our ability to recruit young men and women into dentistry? Yes, very definitely.

Considering the enrollment issue, I would say to you that as dental schools—and I think as medical schools—accepted Federal help in the past, a commitment to increase our enrollment was tied to that Federal support. I mentioned earlier, I believe, that the cost of educating a dental student now is \$24,000 a year. The amount of Federal support, plus the type of programs that have to be implemented to maintain that institutional support, practically utilizes all that institutional support just to maintain the concept of such things as increased enrollment, and extra training programs, which is an excellent means of educating a dental student. But for us to provide that type of training in addition to the other type of dental training literally eats into the entire institutional support we have received.

MR. WAXMAN. You don't expect you will increase your enrollment?

Dr. REESE. No, sir, we do not. The possibility of decreasing enrollment as well as increasing the cost to the student would be very great without institutional support.

Mr. WAXMAN. Dr. Cohen?

Dr. COHEN. We do take somewhat of a different posture regarding the National Service Corps because one-third of our students are enrolled in that and in the Armed Forces scholarship program. We think that is a viable alternative for the student and certainly has beneficial factors for the communities.

I am not so sure that the program has gone long enough for us to look at it and say that we should drop it. As a matter of fact, I think the evidence here today was pretty clear-cut that there is a segment, particularly in some urban areas, of an underserved population, and no matter what we have tried to do in the past we have not been successful, particularly in primary care. I would hope that we could look to the National Health Service Corps for some relief in that.

Who is to say after several years of the program going on with those physicians practicing in the area that they might not be able to locate there on a permanent basis? And I think the program is still too infantile to know whether or not it's going to have any substantive change and how many people are going to locate in primary care in the urban areas.

Mr. WAXMAN. Has it been your experience with those students who are in the Corps that minority or disadvantaged students tend to sign up to go to school and have their way paid with the promise they will serve in these underserved areas?

Dr. COHEN. Well, the osteopathic profession has somewhat a different emphasis, the reason being that the minority application pool is extremely small, and we haven't been able to really make a successful dent in that pool, so that the majority, by and large, of our students in the National Health Service Corps are not minority.

I also am not sure whether it is morally correct to expect a minority or disadvantaged student to only practice in an area of poor economy.

Mr. WAXMAN. It's not morally correct, but I would think the realism would be that students from lower-income families might find that their only avenue to go to a health professional school would be to say they are willing to make the sacrifice to serve in an underserved area to have their education paid for, just as they are willing to serve in the military.

As I understand the AAMC position, they are willing to let the students come in if they promise to serve in the military. They don't see the need to give scholarships for underserved areas. They think that will be taken care of by the surplus of doctors.

Dr. STEMMLER. Let me clarify that, Mr. Chairman. What I am questioning, and what our association is questioning, is the need for the Federal Government to employ physicians to provide services in private communities. That's really the question. It relates to National Health Service scholarships because the scholarships given now drive future expansion of the Corps.

There is an appropriate need for financial aid, but if by providing financial aid, we just continue to increase the Corps of physi-

cians at a very rapid rate, then financially it gets unnecessarily costly. Let's compare a loan forgiveness program for students who might then be excused from a \$40,000 loan by moving into a community, whereas that same physician might cost \$100,000 or more if provided the Corps. It's an important economic question.

Mr. WAXMAN. I don't understand the distinction. You are willing to say a student can take a loan out and then forgive the loan if they serve in an underserved area, but you are not willing to say if a student, at the beginning of his education, says, "I'm willing to have my way paid and then to serve afterward." You don't think that's appropriate. I don't see the distinction. Isn't it better for your students to be faced with what is likely for their future career in the beginning and make that decision and understand it, than to be subject to being drafted to serve in an underserved area, even though their education then will have been paid for because their loan will have been forgiven?

Dr. STEMMLER. The question we are dealing with is whether the Federal Government should be employing a Corps of physicians to provide service to civilians. That Corps is being expanded.

Mr. WAXMAN. We also have alternative service to fulfill the obligation.

Dr. STEMMLER. But the question we are focusing on is a final question, because the Corps is becoming a very expensive undertaking, and we are expanding it while at the same time there is strong evidence that the increase in the availability of physicians is diffusing them into communities where they never went before. A matter of policy I think you should deal with is whether the particular principle on which the Corps was founded is appropriate any longer.

All we are saying is that we not let a scholarship program expand a Corps which may not be necessary any longer. We do need the financial aid. I'm not speaking against that.

Mr. WAXMAN. You do believe we ought to continue aid to the medical schools without phasing that out. Are you interested in discussing any conditions you think are appropriate to that?

Dr. STEMMLER. I may be speaking more personally than the association, although I think I am representing their position accurately. Obviously the Government has a choice. It could disengage from the relationship it has had now since 1965 with the schools of medicine, osteopathic medicine, all the health professional schools.

My point of view is that the relationship has served a very important role, that through the device of our institutions the Federal Government has been able to implement change that it might not otherwise have been able to implement.

Mr. WAXMAN. You're right, because of the surplus of doctors.

Dr. STEMMLER. What I am saying is a matter that I believe personally, and that our association also believes. That it is unwise for the Federal Government to disengage from the schools, and this has nothing to do with the economics. I think we are available as almost unique devices to the Federal Government for doing things it cannot otherwise do without us.

Mr. WAXMAN. If we wanted you to have a family practice program and we had funds to give you, you'd take care of patient service under medicare and medicaid, and we reimburse over \$1

billion to the medical colleges for that now. There is research grant money which goes through NIH, which is one of the major sources of support for the medical schools. The research goes through from NIH to the medical colleges. Why should we give you money because you are good institutions?

Dr. STEMMLER. That's an easy question: Because increasingly the moneys that flow from the Federal Government come to do specific things that must be accounted for precisely in the way those funds get used. We are getting more and more rigid in the way we have to manage and account for funds, and I'm not saying that's inappropriate, we ought to be accountable for everything we do.

What that system of restricted designated funding creates is a system of little fiefdoms—some of them not little, like research.

What these institutional funds provide is the ability to do something that one might not otherwise be able to do, because restriction on the funds that you have gotten from other sources say you cannot.

Mr. WAXMAN. So the other funds are like categorical grants or block grants. You want a revenue-sharing program in addition to the other.

Dr. STEMMLER. Well, in one sense it's like the basic research support grants that helps a research enterprise. When you see an opportunity you can seize the opportunity and do something that no restricted source of funds would allow you to do. In the general operation of a medical center, these funds provide that flexibility.

Mr. WAXMAN. I can understand your position. Thank you.

Mr. Benedict?

Mr. BENEDICT. Dr. Reese, could you help me, please, with your conception or your understanding of what is an adequate level of dental practitioners? I have seen numbers that indicate we may have enough practitioners today to meet the needs by 1990 without educating any more.

Dr. REESE. First of all, at the present time, we do not have the data that we do in medicine, although there have been some regional studies, examination of the manpower supply, and it does appear as if what you say is true.

Certainly the impression is that the same trends are going to be followed in dentistry as they have been in medicine relative to the 1990 figure.

At the present time, in certain regions, and this is tied to a maldistribution problem, we do find surpluses of dentists practicing.

However, in dentistry, at this point in its history, there are some major occurrences that may have a great impact on that. Probably the greatest impact would be the involvement of third-party payment. It has had a profound impact in medicine, and will have an even more profound impact in dentistry, basically because many people feel dentistry is a luxury and they will only go to the dentist, unfortunately, when the situation arises that they are in pain.

We have figures concerning the population and how many of those people seek dental care. It's a very small percentage, quite frankly.

We also know that they look at dental care and the cost of dental care very critically because it's coming out of their own pocket as opposed to going to a physician or a hospital where they may get a receipt, indicating how the third party paid their bill. But in dentistry, it has to come right out of their own checkbook.

We think there would be a profound effect, and probably the greatest effect of increased demand for dental care will revolve around third-party payment. If that occurs within the next decade, and it has been increasing rapidly, then we will see an increased demand for dentistry.

How this will balance out, I don't know. At the present time I think that there is concern, great concern, in both the practicing profession and dental education and is obviously reflected in your comment that the same trend exists as far as an oversupply of dentists.

Mr. BENEDICT. It does raise a question in my mind of whether the taxpayer has a role in continuing to educate dentists when we may have an adequate supply, and the same question occurs with the education of physicians. Would it not be sensible, but—would you comment on a tighter focusing in medical education to meet specific needs within the society, rather than to provide medical service, rather than looking at this as a program to educate physicians, which I see as a much tighter role than what we started with.

Dr. COHEN. I am not so sure as we look at the statistics that they tell the real story. What concerns me is the fact that several years ago, we all got together and said, "We need more physicians," and we predicted by increasing class size and encouraging new schools to start, we would be able to meet the needs of this country.

What we did not take into consideration was that we would still have a lack of primary care physicians and that we would have specialty maldistribution for quite some time. Here we are, some 10 or 15 years later, saying, "My god, we might be in trouble. We've supported too many schools and there are going to be too many doctors."

Mr. BENEDICT. I wouldn't look at it as being in trouble. It's just maybe the need for this program is past.

Dr. COHEN. I guess I have the feeling that—I guess it's more anecdotal because the statistics don't bear it out, but when we hear the people in economy tell us that physicians don't meet supply and demand, they generate their own income regardless of how many, so we ought to stop at a certain number that we think could handle most of the population. I think that has not met the test of time, either, and I guess I feel that as long as my Aunt Sadie complains to me that she has to pay \$110 and sit in a doctor's office for hours, and she can't always get in, there is a doctor shortage.

I guess when I look at my local community and see that the neonatal mortality rate is three times the national rate because there aren't enough people seeing the women who are getting pregnant, or stopping to educate teenage girls who get pregnant, then there are not enough doctors.

And I guess when somebody in a small town has to drive 120 miles to get adequate medical care, there aren't enough doctors.

Now statistics may tell me, yes, there are so many doctors per 100,000 but that isn't always the answer. Perhaps if we continued

at the same rate, we would learn something. We might learn that some of the doctors would have to enter into the supply and demand market and lower some prices competitively. I think perhaps in some areas of other health endeavors that is happening.

I think perhaps we will see doctors in communities that they heretofore would not go into to practice, be able to make a living. So that I look at the medical school—I hope we don't get frightened, turn off the valve, cut down the classes, and 10 years from now really not know where we are.

I would hope that the maintenance of enrollment can continue and, of course, unfortunately we need the support.

Mr. BENEDICT. Dr. Stemmler?

Dr. STEMMLER. I wanted to respond to that question, which conveys the sense that the Federal Government should not subsidize on a per-student basis the education of individual students? We have shifted from a policy consideration that began early in the 1960's which said it would be useful to use a per capita funding mechanism to provide an incentive for expansion in our institutions.

It strikes me that the per capita logic served a very useful purpose, but we are now in a period where it's not an appropriate logic any longer. We are trying to convey today that we cannot argue the case for institutional support on the basis of subsidizing the education of each medical student who will, in fact, have a chance of being one of the high earners of society. Rather, if there is an argument, it's got to be made on the basis of the Federal need for our institutions, which have complex missions have to do things which we cannot otherwise do if we do not have funds to carry out the desires of Federal health policy.

One of the issues that you dealt with earlier in your discussion with the representative from The Robert Wood Johnson Foundation is how do you get at the underserved core? That's very difficult to do at a Federal level because this country is so diverse. Give one of our institutions in a local setting a chance to deal with it. We have a better chance of solving those problems than the Federal Government, but we need the wherewithal to do it.

Mr. WAXMAN. Would the gentleman yield?

Mr. BENEDICT. Yes.

Mr. WAXMAN. Tell us what the medical schools are doing to meet the maldistribution problems. What is being done to develop more students in specialties for family practice as opposed to the surgical specialties?

Dr. STEMMLER. The question is——

Mr. WAXMAN. What have you done for us lately?

Dr. STEMMLER. Who promoted the establishment of the family practice programs which were established in relation to the schools of medicine? Who went out and worked with communities to get these things done? That's us.

Mr. WAXMAN. That's our money.

Dr. STEMMLER. That's not all your money. There is a money mix.

Mr. WAXMAN. We ought to continue the money for those programs?

Dr. STEMMLER. Of course. And we agree with that, and what we are saying is in addition to those special projects, and again this is

your judgment as to how it compares to Mr. Dannemeyer's previous statement—you've got to make a judgment as to whether or not institutional support is a useful investment in the future.

Mr. WAXMAN. You mentioned family practice. What else are you doing to take care of the underserved needs of the people in the urban areas?

Dr. STEMMLER. The development of general medicine and general pediatrics, establishment of neighborhood health clinics, the establishment of models of practice comes out of the academic centers.

Mr. WAXMAN. What support do the medical schools give now to the neighborhood clinics? Some personnel obviously come through institutions.

Dr. STEMMLER. I don't know the percentage. I'd have to ask my expert resources behind me, but in the large metropolitan areas, most of the indigent care is provided through institutional care—provided by our institutions and subsidized by them.

Mr. WAXMAN. And isn't it true that care given by the teaching hospitals is reimbursed at a special rate under the medicare-medicaid program, so it's not volunteered by the medical schools?

Dr. STEMMLER. No, I disagree with that. That is not completely true. There is, for example, in the University of Pennsylvania over \$2 million in annual free care provided by that institution. That is not subsidized by anybody.

Mr. WAXMAN. But a great portion of the medicare and medicaid services in the teaching hospitals are reimbursed specifically for teaching hospitals, are they not?

Dr. STEMMLER. The medical program in the Commonwealth of Pennsylvania, as an example, provides \$6-\$8 a patient visit for cost of a patient visit that runs \$17-\$20.

Mr. WAXMAN. How about inpatient? That's outpatient.

Dr. STEMMLER. Inpatient we are compensated for, but we were talking earlier about access to outpatient care, and the large institutions provide care. We cannot walk away from it. We provide it.

Mr. BENEDICT. Thank you, Mr. Chairman. I yield the balance of my time.

Mr. WAXMAN. Mr. Whittaker.

Mr. WHITTAKER. I just have one question. It has two parts. I'd like each of you to answer it, if you would, please.

I'd like to apologize, while I was gone on the vote, if I touch on a subject that's been touched on before, but would each of you estimate what percentage of your capitation grants go for the general revenues of your separate schools?

And then second, do you believe that your institutions are prepared, should the Federal Government withdraw its support, to raise the tuition and seek funding from other sources?

Dr. COHEN. Sir, could you repeat that?

Mr. WHITTAKER. Yes. Are you prepared to increase the student fees, tuitions, to cover the cut-back in Federal funds?

Dr. COHEN. We are a State institution and as such we have one of the highest tuition levels in the Nation. It's going from 5,000 to 5,500 per year, which for a State school is high. So we have had to make those provisions to cover the expenses of the institution.

Mr. WHITTAKER. How much of your current budget is funded by the Federal Government now, per student?

Dr. COHEN. I would have to get those exact figures. They are not with me. The majority of support that we get is State support.

Dr. STEMMLER. I'm not sure I can quote an exact percentage. I would say on a relative number, the Federal support provided through the capitation, as a percentage of total revenue, is a very small percentage, but that fact, as I emphasized before, does not lessen its importance as unrestricted revenue. As a portion of unrestricted revenue to schools, it's a much higher percentage. We will be glad to provide that information in our written submission to follow.

What would we do, if the support were withdrawn? The response would be different depending upon whether I'm speaking for a State school or a private school. In a State-supported school, the capitation, institutional support, represents a principal source of unrestricted revenue which, if lost, is not necessarily made up by State appropriation. The State schools have a particular problem in not being able to reflect that loss in their tuition. Tuition levels depend, obviously, on the desire of each individual State legislature.

In the private schools, we have within our power the decision to choose to offset dollar for dollar or less than dollar for dollar. I think most of us feel that the money that would be lost is not entirely the responsibility of students, since we do not think that students, through tuition, ought to be funding programs that relate to national health policy. We think they have enough of a problem in financing their own personal education, and that is an inappropriate burden to put on their back.

I know to my own students I have promised that we would not offset it dollar for dollar.

Mr. WAXMAN. Would you yield to me?

Mr. WHITTAKER. Yes.

Mr. WAXMAN. I want to ask you what national policy is served by the institutional support money. Isn't that money that allows you flexibility for salaries? Isn't it controlled by the dean for the needs as he sees fit for the institution?

Dr. STEMMLER. Exactly.

Mr. WAXMAN. That may be our national policy in a broad sense, but—

Dr. STEMMLER. If you believe our institutions are useful in providing change, and I think our record is that is in fact what we have done, then, yes, that money is useful in implementing national policy.

Dr. REESE. At my particular dental school, I believe it's approximately 6 percent. My expert has informed me that across the Nation it's approximately 6 percent, and much, much higher in private institutions. We at the University of Maryland are not prepared to raise our tuition to replace capitation funding. Our tuition has been going up rapidly in our particular institution, and I think across the Nation.

On the other hand, I think what most dental schools are prepared to do is in fact reallocate resources, which means lose programs that the original institutional support provided for. I think you have to remember the tremendous investment that this institutional support has meant to the Nation over the past many years.

I disagree somewhat that it's a fund that the dean utilizes. It's a fund that the school utilizes for projects, very specific projects. Many times funded projects which have been supported elsewhere are continued through the utilization of institutional support, such as teaching special care for handicapped, such as providing for curriculum development, experimentation in delivery systems, geriatric dentistry, nutritional counseling.

We send our students, as an example, out to some of the highrise homes for both handicapped as well as the aged, and provide nutritional counseling. This institutional support has been, and I hope will continue to be, an investment to these schools who have been innovative and have had the initiative in the past to utilize these funds for good programs and total education, and likewise I think for medical schools.

I think that I really know of no program other than the student loan program that has been a better investment than the institutional support, in my opinion.

Mr. WHITTAKER. Thank you.

Mr. WAXMAN. Mr. Dannemeyer.

Mr. DANNEMEYER. Dr. Reese, I note on page 11 of your testimony, you indicate that your association supports phasing down the national health service goals of your program to a level that is consistent with realistic shortage requirements.

You further note that programs such as the national health profession placement network are realistic methods to match community need and health manpower availability.

Can you tell us what the national health profession placement network is, and whether it is working?

Dr. REESE. I believe it is working. Very briefly, it is a computerized program to match a location that needs a dentist, with a dentist that needs a location. It's as simple as that. It's a program that was developed initially at the University of Minnesota, I believe, just for Minnesota, and now has expanded further.

Mr. DANNEMEYER. How is it funded?

Mr. REESE. I'm not sure of the exact funding source. The Kellogg Foundation. A dental student always knows more than the dean.

Mr. DANNEMEYER. But isn't it true that professionals have a tendency to want to practice where the living is good, which tends to mean people avoid, I suppose, rural America, because the social amenities aren't what some perceive they ought to be for those earning what professionals of the medical profession are able to earn? Isn't that pretty much commonsense?

Dr. REESE. Well, it's common sense, I think, to live where the living is good. I think one possible way which may in fact be the best way to offset maldistribution may be to in fact recruit dental students and medical students from areas where there is some degree of underserved, underrepresented groups. This is an area that we have been involved in and we have developed the pipeline program to begin to bring the students in from underrepresented areas and, in fact, it seems to be that there is going to be a return although it's a little bit early to tell.

Mr. DANNEMEYER. Are you familiar with California? Blythe, Calif., or cities down toward the southern boundary of California? It gets up to 120 degrees in the summertime and there's not too

much breeze. About the only way you can get a professional to go down there is to have them work off the taxpayers' funds provided for his or her education, and after they serve their time, in that paradise in the wintertime, then they can get out of there. What's wrong with that?

Dr. REESE. Well, I don't think that's a lasting resolution for California. I think possibly one resolution of that problem may in fact be to go down into those areas that you have named and recruit students from those areas. That's a long-term process sometimes. It requires support at the undergraduate level, beginning even in high school.

As an example, we bring students from these areas in Maryland—believe it or not, we have areas in Maryland that are considered remote—and we bring them into our health science campus to begin early in their careers.

Now I submit to you that possibly there are people who are born and brought up in those areas who might like to return to their home and they think that is a better place to be.

Mr. DANNEMEYER. Are other professions acting in a manner similar to the profession of dentistry?

Mr. WAXMAN. If you would yield to that, I don't think dentistry is saying they are placing people in God-awful places. They are placing people where there are jobs available and where they are willing to go.

Dr. REESE. There are two concepts we are talking about. I first explained to you the health profession placement network. That is a matching service. Now what I am referring to now really in my opinion may be a long-term solution to the maldistribution. That is, go to those areas where there is a shortage and try to recruit individuals from those areas. I think more than likely they would return to their home State, their home city, their home county and remain there.

The problem I think at the present time is whether they will remain there.

Mr. WAXMAN. Should the Federal Government require schools to take students from those underserved areas, or should the Federal Government pay for their education?

Dr. REESE. That's a similar question asked me by a State senator from western Maryland. I would hate to respond to that question, quite frankly, because first of all, I think that in our own admission criteria at the University of Maryland, we do have geographic representation as one of our criteria for admission.

That does not say, by the way, that we will always take a student from Allegany County, Md., just because it's in a far area of the State. That says we will give the student from that area consideration; maybe consideration over another student of equal grades, et cetera. But we are not—I don't think I am advocating at all the bringing into professional schools students who, quite frankly, would not be able to negotiate the curriculum.

Mr. WAXMAN. So you are not making a policy decision on the admission or education of students, how to serve those areas not being served. You are working on a different level completely. And the reason I say that is while you may think it is not a long-term answer for the Federal Government to pay for the student's educa-

tion in exchange for their promise to serve in those underserved areas, it doesn't seem to me you are giving us a long-term answer, either, by telling us you have a Kellogg Foundation grant to place dentists in a job where they are willing to go.

Dr. REESE. I think the network is presently being funded by Kellogg and is successful. I would say to you that not only are we considering individuals—I don't think the dental school at Maryland is different—we are considering individuals from geographic locations. We also do other things with our institutional support, and one of those things is to continue the process through extramural training of sending students out into those areas so that they can live a month at a time in possibly the area that you are talking about and it might strike their fancy to return to that area.

So I disagree with you. I think we are providing institutional support to offset the maldistribution problem. I think there is a multiple approach to attacking it.

Mr. DANNEMEYER. Thank you, Mr. Chairman.

Mr. WAXMAN. I just want to comment that it seems to me that a multidimensional approach to attacking these societal problems starts with getting money from the institution first and suggesting that we not give money to the only program that guarantees a health professional to go into an underserved area—it seems to me we've got to look at the whole range of problems and decide to what extent the Federal Government ought to be involved in solving these problems.

I don't doubt the money we give to the institutions is well spent on projects that serve society, just as your institution does. The question we have to decide is, Should we be putting Federal money into that? Or should we say to the medical schools, the dental schools, and the osteopathic schools, "We are sorry, but we can't fund everything," just as you are saying to us—"You realize we can't fund everything cut the student's scholarship money for the underserved areas first"?

That's my only comment on that, and that's something we will have to think about and work together to resolve.

I thank you gentlemen very much for your presentation.

This concludes our hearing for today. We will be meeting next week on March 12. At that time we will hear from the veterinary, optometric and podiatry and pharmacy schools, and a number of other professional associations.

[Whereupon, at 5:40 p.m., the hearing was adjourned.]

HEALTH MANPOWER LEGISLATION

THURSDAY, MARCH 12, 1981

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:45 a.m., in room B-352, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. I would like us to get started if we might. Others will be joining us as the morning progresses.

Today the subcommittee continues its hearings on the health professions education legislation.

Last week a number of manpower experts presented trends in the distribution of health professions. Our witnesses predicted that while the United States will have 150,000 more physicians by 1990, most of these additional doctors will be trained in surgery and subspecialties and will locate their practices in the suburbs and small cities. The financial and professional incentives for specialization and practice in currently well-supplied areas are overwhelming.

This morning we will hear about the recruitment and education of students from disadvantaged backgrounds.

Today fewer than 2 percent of practicing physicians, in contrast with 11 percent of the U.S. population are black. Despite a decade-long effort, only 6 percent of first year medical students are black. Similarly, Hispanics, Indians, other minorities, and whites from rural and less affluent backgrounds are substantially underrepresented among health-care students and practitioners. The continuing shortage of disadvantaged students forecasts these communities will remain underserved for years to come.

Witnesses from a number of the health professions schools, the AMA, the area health education centers will also be appearing before us this morning.

Before I begin to recognize our panel of first witnesses I would like to recognize the distinguished ranking minority member of this subcommittee, Congressman Madigan, for any comments he wishes to make.

Mr. MADIGAN. Mr. Chairman, thank you for the kind introduction. I will forgo the opportunity to make an opening statement in view of the number of witnesses that we have and the busy schedule that I have otherwise today and that I know you have as well. In order to hear as much as we can from the witnesses I would prefer to just get started with them.

Thank you.

Mr. WAXMAN. Our first panel this morning will discuss programs to recruit and retain students from disadvantaged backgrounds. Dr. Paul Elliott of Florida State University has twice been the chairman of the AAMC Task Force on Minority Student Opportunities in Medicine. Dr. Louis Sullivan is the dean of the new medical school at Morehouse College in Atlanta.

I would like to ask both Dr. Elliott and Dr. Sullivan to come forward.

Dr. Elliott, why don't we proceed with you. I might in opening, before you begin, say to you and other witnesses that will be appearing before us today that since we have a very lengthy agenda, as I am sure all of you have been informed, we will make all of your written statements in their entirety part of the record. We would ask you to summarize the key points in no more than 5 minutes so that we can have an opportunity for questions and answers.

STATEMENTS OF PAUL R. ELLIOTT, PH. D., ASSOCIATE VICE PRESIDENT FOR ACADEMIC AFFAIRS, FLORIDA STATE UNIVERSITY; AND LOUIS W. SULLIVAN, M.D., PRESIDENT, ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS, ACCOMPANIED BY THE FOLLOWING ASSOCIATION MEMBERS, RALPH H. HINES, PH. D.; WALTER C. BOWIE, D.V.M., PH. D.; ANTHONY RACHAL, M.E.D.; AND CHARLES A. WALKER, PH. D.

Dr. ELLIOTT. Thank you, Chairman Waxman, distinguished members of the committee.

I have been introduced, but I will repeat that I am Paul Elliott, associate vice president for academic affairs from Florida State University. I come primarily as a highly involved participant in the development of access to health careers for nontraditional groups, particularly racial minority students, rural students, and students from backgrounds of low socioeconomic status.

My credentials, if you will, that bring me to testify before you include chairmanship of the Task Force on Minority Student Opportunities in Medicine for the Association of American Medical Colleges.

Also I was one of the codevelopers of the simulated minority admissions exercises, an innovative approach to the admission of nontraditional students to the health professions.

Finally, I was the initiator and for 7 years the director of the program in medical sciences which is an innovative joint effort involving Florida A. & M. University, Florida State University, and the University of Florida College of Medicine. One of that program's primary goals is to increase the number of minority and rural physicians practicing in underserved areas of Florida, as well as segments of Georgia and Alabama.

I will mention one disclaimer. If I put too much emphasis on medicine rather than other health careers and if I put too much emphasis on blacks as a minority, it is not because of lack of interest in other health careers or other nontraditional groups, it is simply my familiarity with medical education and with the Southeastern region as well as the fact that both more data and more precise data are available for analysis in the area of medical education.

My points are straightforward. I am going to make four of them which I trust will link together in a common thread with the testimony of Dr. Tarloff and others who last week discussed with you the singular problems of health-care distribution.

My first point would be that a continuing and visible concern of our society, of the Federal Government and of health professions education institutions is the imbalanced distribution of health professionals, particularly physicians, both geographically and by specialty.

The need for increased numbers of primary care professionals and of health professionals who will practice in severely underserved areas, particularly rural and inner city, continues almost unabated.

The second point is that minority students are more likely to practice medicine in support of the educational underserved areas as indicated in a number of recent studies.

Studies of Colita and Craig in 1976, of Lloyd, Johnson and Mann in 1978, both indicate very clearly that minority graduates, in this case minority graduates of Howard University, are more likely than their majority counterparts to select a primary care specialty and more likely to serve a patient population of significant minority and low socioeconomic composition.

In the Lloyd study of Howard University graduates, for instance, it was shown that 92 percent of Howard's minority physician graduates serve populations with an average of 72 percent minority patients. That is clearly the opposite of what happens with traditional and majority graduates.

A more recent study in California by Bob Montoya, director of the California health careers opportunity program, indicates a similar response pattern for Chicano and other minority dentists in the State of California.

There exist a variety of other studies which I will not quote but which relate to rural background and other demographic characteristics, including low socioeconomic status, family educational level and geographic site of childhood. These all have a positive impact on primary care specialty selection and on particular practice patterns in underserved areas. In general the more nontraditional the student the more likely he or she will select a practice pattern involving primary care for underserved populations.

The third point is that those same disadvantaged and minority students who as health professionals would improve the health care for underserved populations are themselves handicapped by weaker academic preparation, by a lack of role models, by inappropriate support systems and a host of other factors which collectively prevent an increase in the pool size of disadvantaged and minority applicants in all of the health professions.

This singular problem of applicant pool size was identified in 1978 in the report of the "Minority Student Opportunities" task force of the Association American Medical Colleges (AAMC), as the primary problem to be addressed. There is less problem with selection rate for minority students and for disadvantaged students. The more difficult problem is the number of applicants from such groups.

The attached information from the AAMC indicates that a constant pool size has been characteristic of all minority group applicants to medicine over the past 5 years.

The fourth and final point is that the single most effective program which continues to address the problem of applicant numbers and quality for disadvantaged and minority populations is that entitled the "Educational Assistance to Individuals From Disadvantaged Backgrounds" in H.R. 2004 known to us as the health careers opportunity program of HRA.

It is singularly important that we continue and, if possible, increase the support in this program which uniquely addresses the questions of identification, academic enhancement, admission, retention, graduation, and placement of minority and disadvantaged health professionals.

One final set of data which is probably the most interesting of all came out of a recent HRA study—of December 1980—which reinforces the importance of the HCOP programs. This shows that for the medical schools which received HCOP grants—earlier called Student Health Career Opportunity Grants—over the last 8 years, the rate of admission of minority students was twice that of the rate of admission of medical schools without HCOP support; 12 percent versus 6 percent.

I would add that the HCOP program leads the way in encouraging strong cooperation among the various health professions schools, and between those schools and their communities, the high schools and the colleges and universities which are integral parts of the health professions education pathway.

If I might review those four basic points: No. 1, we still need improved health care distribution; No. 2, disadvantaged and minority students are more likely to practice health professions at a primary care level with underserved populations; No. 3, the applicant pool of minority students is not increasing and we need to improve that; No. 4, the best means of rectifying that problem of applicant pool size is through support of the HCOP programs and of strong minority health professions schools.

Thank you for the opportunity to address you. I would be happy to answer questions.

[Dr. Elliott's prepared statement follows:]

Paul R. Elliott, Ph.D. Associate Vice President for
Academic Affairs, The Florida State University
Tallahassee, Florida

Chairman Waxman, and members of the Committee, my name is Paul Elliott; I am Associate Vice President of The Florida State University, and a highly involved participant in the development of access to Health Careers for non-traditional groups - particularly racial minority students, rural students, and students from low socio-economic backgrounds.

The "credentials" which bring me the privilege of testifying before this committee include the following:

I am one of the developers of the highly successful Simulated Minority Admissions Exercises, sponsored by the Association of American Medical Colleges (AAMC) and funded in part by a Health Careers Opportunity (HCOP) grant from the Health Resources Administration. This six-year-old program over the last two years alone has resulted in nearly forty workshops (15 were HCOP supported) involving more than 1200 faculty, staff and students involved in Health Professions admissions, recruitment and retention programs for non-traditional applicants.

I was the developer and for seven years the Director of the Program in Medical Sciences, a joint M.D. program involving Florida A & M University, The Florida State University and the University of Florida College of Medicine. A primary goal of this program has been and continues to be an increase in minority and rural practitioners with a particular emphasis on primary health care.

And finally, I was Chairman of the Association of American Medical College's Task Force on Minority Student Opportunities in Medicine which reported to the Association in 1978 on a number of critical issues involving recruitment, reinforcement, retention and graduation of racial minority group medical students.

One disclaimer is appropriate: if I speak to you today with more emphasis on medicine and more emphasis on Black concerns, it is not because of a lack of interest for other health careers or for other non-traditional groups, it is simply my familiarity with medical education and with the Southeastern region as well as the fact that both more data and more accurate data are available for Black students and for medical education.

HEALTH CARE DISTRIBUTION

A continuing and visible concern of our society, of the Federal and State governments, and of Health Professions institutions is the imbalanced distribution of health professionals, particularly physicians, both geographically and by specialty. The need for increased numbers of primary care physicians and of health professionals who will practice in medically underserved areas - particularly rural and inner city - continues almost unabated. The precise numbers need not be presented here; you heard them from Dr. Tarloff last week.

MINORITY PHYSICIAN PRACTICE PATTERNS

A singular argument in support of Educational Assistance Programs for the Disadvantaged and of other components of HR 2004 which furnish support to Minority Health Professions Schools can be observed in the studies of Koleda and Craig (1976) and of Lloyd, Johnson and Mann (1978). Both of these studies indicate that minority physicians (in these studies, Black physicians) are more likely to serve a patient population of significant minority and low socioeconomic composition. In the Lloyd study of Howard University graduates for example, 92% of Howard's minority physician graduates are shown to serve patient populations with a predominant minority composition (averaging 72% minorities). A study by Dr. Robert Montoya in California indicates a similar response pattern for minority dentists (particularly Chicano) in that state.

A variety of additional studies in many regions of the country indicate that demographic background, including such factors as socioeconomic status, family education level, and geographic location of childhood have a significant impact on specialty choice and practice pattern. In general, the more non-traditional the student, the more likely that that student will subsequently elect a primary care practice in a medically underserved area.

ACCESS of the DISADVANTAGED to HEALTH CAREERS

And yet, if it is true that increased access to health careers for persons of disadvantaged and minority background could result in improved distribution of health care, it is also true that those same disadvantaged and minority students continue to be handicapped by poorer academic preparation, a lack of role models, inappropriate support systems and a host of other factors which collectively prevent an increase in the pool of such applicants.

The singular problem of applicant pool size was identified in the 1978 Task Force on Minority Student Opportunities in Medicine (AAMC) as the primary problem to be addressed in the 80's. More recent information from the AAMC (Table 1) indicates that a constant pool size is characteristic of all minority group applicants to medicine over the past five years, resulting in a relatively constant and unacceptably low rate of admission for such students.

HPEA PROGRAMS AND THE APPLICANT POOL

The single most effective program which continues to address the problem of the size and quality of the applicant pool of disadvantaged and minority populations is the program entitled "Educational Assistance to Individuals from Disadvantaged Backgrounds" (HR 2004); known to us as the Health Careers Opportunity Program of HRA.



association of american medical colleges

TABLE 1

Number of Applicants, Acceptees, New Entrants and Enrollees
for the 1974-75 to 1979-80 academic years by
selected racial/ethnic groups

	Black American	American Indian	Mexican American	mainland Puerto Rican	All Minorities
Applicants					
1974-75	2,423	134	440	177	3,174
1975-76	2,288	132	427	202	3,049
1976-77	2,523	128	460	212	3,323
1977-78	2,487	122	487	203	3,299
1978-79	2,564	133	433	191	3,321
1979-80*	2,592	150	456	173	3,371
Acceptees					
1974-75	1,049	64	217	76	1,406
1975-76	945	57	220	86	1,308
1976-77	966	39	223	85	1,313
1977-78	966	43	227	93	1,329
1978-79	970	55	241	92	1,358
1979-80*	1,017	63	266	91	1,437
New Entrants⁺					
1974-75	950	70	199	63	1,282
1975-76	893	57	207	70	1,227
1976-77	935	41	239	76	1,291
1977-78	959	46	216	-	-
1978-79	938	51	237	-	1,317
1979-80*	970	55	255	88	1,368
First Year Enrollees					
1974-75	1,106	71	227	69	1,473
1975-76	1,036	60	224	71	1,391
1976-77	1,040	43	245	72	1,400
1977-78	1,085	51	246	68	1,450
1978-79	1,061	47	260	75	1,443
1979-80	1,108	63	290	86	1,547

* Current as of September 28, 1979.

+ 1974-75 to 1977-78 data on New Entrants are taken from JAMA. The discrepancy that exists between JAMA's new entrants figures and AAMC's acceptees figures is due to time and way in which the data are collected and to the unknown race of some applicants.

- Indicates data not available.

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It is singularly important that we at least continue and if possible increase the support of this program which uniquely addresses the questions of identification, academic enhancement, admission, retention, graduation and placement of minority and disadvantaged students who are interested in a health profession.

One final set of data from an HRA study of December, 1980, should reinforce the importance of the HCOP programs. This study shows that the rate of admission of minority applicants to medical schools which received HCOP support between 1972 and 1980 was above 12%, twice the rate for admission of minority applicants to medical schools which received no HCOP (or SHCOG) support during that period.

And finally, the HCOP program leads the way in encouraging strong cooperation among the various health professions schools (both MODVOPP and Allied Health) and between those health professions schools and the communities, high schools, colleges and universities which are integral parts of the health professions education pathway and our health care delivery system.

SUMMARY:

In review and summary, the logic of my testimony is both clear and well documented:

1. This country has yet to resolve the problem of the distribution of health care to many of its citizens.
2. Disadvantaged and minority students are more likely to enter a practice pattern which improves access to health care for underserved populations.
3. The rate of admission of disadvantaged and minority applicants to health professions schools is limited by the size of the applicant pool which continues at a level about one-half that of minorities in the population as a whole.
4. The best means of rectifying that problem of pool size (and hence, of access) is through increased support of the HCOP program and of strong Minority Health Professions Schools.

I thank you for the opportunity to address you today on this exceedingly important manpower issue.

Mr. WAXMAN. Thank you very much, Dr. Elliott.

Dr. Sullivan, we would like to hear from you next and then we will have questions for both of you.

STATEMENT OF LOUIS W. SULLIVAN, M.D.

Dr. SULLIVAN. Thank you.

Chairman Waxman and members of the committee, I am Louis W. Sullivan, dean and director of the school of medicine at Morehouse College and president of the Association of Minority Health Professions Schools.

The Association of Minority Health Professions Schools includes several institutions whose representatives are accompanying me here today.

In addition to Morehouse, it includes Meharry Medical College. Dr. Ralph Hines, executive vice president of Meharry, is with us today and I would like to ask him to stand and be recognized.

The Charles R. Drew Postgraduate School in Los Angeles, and unfortunately Dr. Haynes is out of the country and could not be with us today but is an active member of the association.

The Tuskegee Institute School of Veterinary Medicine with Dean Walter Bowie from Tuskegee.

Xavier University School of Pharmacy, Mr. Rachal, the vice president of Xavier.

The Florida A. & M. School of Pharmacy, Dean Charles Walker.

The Texas Southern University School of Pharmacy, Dean Patrick Wells.

We are grateful for the opportunity to share our views with you. We are very much aware of the economic constraints that exist in our country and the realities which all of us face as a nation. However, the investment of public resources in the training of health personnel is a wise investment to maintain and enhance our Nation's strength.

Congress has declared the health professions personnel are a national resource and it is therefore appropriate to provide support for the education and training of such personnel.

We seek to reach this goal through a partnership with the Federal Government and the Association of Minority Health Professions Schools in order to correct problems of underrepresentation of minorities and women in the health professions, problems of geographic maldistribution and the need for health professionals trained in primary care.

Significant numbers of our graduates provide health services to communities with large numbers of persons who are socially and economically disadvantaged. However, much remains to be done.

For example, while blacks comprise almost 12 percent of our population we represent only 2 percent of the physicians, 1.8 percent of the dentists, 2 percent of the pharmacists and 0.7 percent of the veterinarians in the country. Similar deficiencies exist for health professionals from other minority groups. The critical need for more minority health professionals is apparent.

Although it has been projected that the United States may have an adequate overall number of physicians by 1990, serious deficiencies remain in health manpower in many areas of the country.

Some 40 million of our citizens still live in areas officially recognized as medically underserved. A shortage of primary care physicians exists both in the inner cities and our rural areas. Federal support is therefore needed to address these national needs.

From the schools of the Association of Minority Health Professions have graduated 90 percent of the Nation's black veterinarians, 50 percent of the Nation's black pharmacists, 43 percent of the Nation's black physicians and dentists. Some 76 percent of these physicians are engaged in primary care.

It is critical that the capacity of our institutions be strengthened to educate and train the kinds of physicians, dentists, pharmacists and veterinarians needed by the Nation. There is no oversupply of minority health professionals. Rather there is a serious deficiency of minority health professionals which represents a national crisis.

During the 10-year period from 1971 to 1981 the percentage of freshmen medical students who are black decreased from 7.1 percent in 1971 to 6.6 percent in 1981. The percentage of medical graduates who are black remains at less than 6 percent. From 1971 to 1979 the percentage of black freshmen dental students declined from 5.2 percent to 4.4 percent.

For blacks to achieve parity of representation in the health professions we need some 42,000 black physicians rather than the 9,000 which exist. We need 15,000 black dentists instead of the existing 3,000. We need 15,000 pharmacists instead of the 2,500. We need 4,300 black veterinarians but there are only 252 in the Nation.

The legitimate and serious needs of our minority poor and disadvantaged citizens for more health professionals should not be denied or held hostage by the controversy concerning overall health manpower projections of the Nation.

Manpower shortages in poor and disadvantaged communities have contributed to an array of serious health problems in our rural and inner-city communities, including a shortened life expectancy for blacks of some 6 to 8 years less than for whites, an almost twofold infant mortality rate among blacks, a twofold greater incidence of high blood pressure and many other brutal statistics.

The institutions of the association are working diligently to supply needed health manpower for our Nation's poor and disadvantaged citizens. We therefore propose that incentive grants be given to health professional schools which respond specifically to these identified national priority needs.

We commend and applaud the subcommittee's recognition and support of the concept of financial distress grants to assist several of our institutions who face possible loss of accreditation or subversion of quality educational programs without such assistance.

We recommend that the committee recognize two levels of financial distress for our institutions and deal with these needs differentially.

Mr. Chairman, we are concerned about the increasing number of low- and middle-income students who cannot afford a health sciences education. Their skills are needed to improve the quality of life for all Americans. Yet, the economics of the 1980's could force

our institutions to seek only those students who could afford to pay from their own resources for graduate and professional education.

Therefore, we support a student financial assistance program that would maintain the democratic concept of choice. An effective student assistance program is needed. We support the continuation of the national health service corps scholarship program, we urge that the exceptional financial need scholarship program be extended to second-year students and we recommend that interest subsidies be continued for loans to needy students in order that these students have a more reasonable fixed financial liability. New health manpower legislation should insure that the health careers opportunity program is upgraded and expanded.

In order that the institutions of the association obtain and maintain their accreditation facilities of acceptable standards must be constructed. Therefore, we are pleased that the subcommittee has included a section in H.R. 2004 for the construction of medical education facilities to assist 2-year medical schools develop those facilities needed to become 4-year schools.

The Liaison Committee on Medical Education requires as a condition for accreditation of new 2-year schools that they develop into M.D. granting institutions. We are therefore pleased that the subcommittee has included authorization for conversion support of 2-year medical schools to meet this requirement of the liaison committee. However, we recommend that the amount of such grants be increased to \$50,000 per third-year student rather than \$25,000 since \$50,000 existed under previous authorities.

In summary, the institutions of the association urge the following:

The enactment of authority for institutional support to assist minority health profession schools meet national priority needs.

That financial distress grants be enacted with two levels of financial assistance.

The enactment of an improved student assistance provisions.

The enactment of an improved health careers opportunity program.

The inclusion of authority for construction grants to new 2-year schools and the inclusion of authority of conversion projects.

Chairman Waxman and members of the committee, the critical shortage of minority health professionals continues to be a national problem which requires a national solution. The members of the Association of Minority Health Professions Schools are in the forefront of health professions institutions which are addressing this issue in a significant way.

For the ultimate success of this partnership between the Congress and our minority health professions institutions an ongoing dialog is required. We look forward to the opportunity for such a dialog between this committee and the Association of Minority Health Professions Schools.

The decade of the 1970's witnesses significant increases in the number of minority health professions but the national goals which were set in 1970 were not met. The decade of the 1980's presents us with a new opportunity to address this challenge. Federal support for the training of needed health professionals from minority and disadvantaged backgrounds must not be compromised.

There is still much unfinished business on our national agenda to assure equality of opportunities for minorities in the health professions and to provide equal access for minorities to health care for our poor and disadvantaged citizens.

Such efforts to improve the health status of our poor and minority citizens and to keep alive the American dream of equal opportunity are as important today as yesterday. Indeed, a healthy citizenry with a continuing belief in the American dream is of prime importance in our efforts to maintain a strong republic and to keep our position of leadership among the nations of the world.

Thank you very much.

[Testimony resumes on p. 284.]

[Dr. Sullivan's prepared statement follows:]

Testimony on the Health Professions Educational Assistance and Nurse
Training
Amendments of 1981 (HR 2004)

Submitted to the Subcommittee on Health and the Environment
of the
Committee on Energy and Commerce
United States House of Representatives

by

The Association of Minority Health Professions Schools

School of Medicine at Morehouse College (Atlanta)
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March 12, 1981

Washington, D.C.

Chairman Waxman and members of the Committee, I am Louis W. Sullivan, Dean and Director of the School of Medicine at Morehouse College and President of the Association of Minority Health Professions Schools. I am representing the Association of Minority Health Professions Schools, which includes the School of Medicine at Morehouse College; Meharry School of Medicine; the Meharry School of Dentistry; Charles R. Drew Post Graduate Medical College; Tuskegee Institute School of Veterinary Medicine; Xavier University College of Pharmacy; Florida A&M University School of Pharmacy; Texas Southern University School of Pharmacy.

A. Institutional Support

With the passage of the Health Professions Educational Assistance Act of 1963, Congress declared that the availability of high quality health care to all Americans is a national goal. Congress declared that health professions personnel are a national resource and that it is therefore appropriate to provide support for the education and training of such personnel. We seek to reach this national goal through a partnership between the federal government and the health professions schools, in order to correct problems of underrepresentation of minorities and women in the health professions, geographic maldistribution, and the need for health professionals trained in primary care.

In concert with the commitment of the Congress that the health care system provide all Americans equal access to health care, the members of the Association of Minority Health Professions Schools wish to highlight the contributions of our institutions in the

training of health professionals for poor and disadvantaged communities. Significant numbers of our graduates provide health services to communities with large numbers of persons who are socially and economically disadvantaged. However, much remains to be done. For example, while blacks comprise almost 12 per cent of the U.S. population, blacks represent only 1.7 per cent of the physicians, 1.8 per cent of the dentists, 2.0 per cent of the pharmacists and 0.7 per cent of the veterinarians in this country. Similar deficiencies exist for health professionals from other minority groups. The critical need for more minority health professionals is apparent.

Support from the federal government, in the form of capitation and special project grants, has been given to increase the number of physicians in the United States. Health professions schools have responded by doubling the number of physicians trained annually.

Although it has been projected that the United States may have an adequate overall number of physicians by 1990, serious deficiencies remain in health manpower in many areas of the country.

Some 40 million of our citizens still live in areas officially recognized as medically underserved. A shortage of primary care physicians exists both in the inner cities and our rural areas. Federal support is therefore needed to address these national needs.

Institutional support is an investment by the nation to enable institutions to maintain high standards. This investment is returned to the nation in the form of uniquely qualified health professionals to meet the following national needs:

1. More individuals from underrepresented minorities
2. More individuals from socioeconomically and educationally disadvantaged backgrounds
3. More women for health professions careers
4. A higher percentage of graduating medical students selecting family medicine residencies
5. Recruitment of students from health manpower shortage areas
6. Education in nutrition, geriatrics, preventive medicine, cost containment and other priority areas.

From the schools of the Association, 50 per cent of the black pharmacists in the U.S. have graduated; 90 per cent of all black veterinarians in the U.S. have graduated (from Tuskegee Institute School of Veterinary Medicine) and 43 per cent of all black physicians and dentists in the United States were graduated from Meharry Medical College (and 76 per cent of the graduates of Meharry Medical College are engaged in primary care.)

It is critical that the capacity of our institutions be strengthened through new legislation, to educate and train the appropriate kinds of physicians, dentists, pharmacists and veterinarians needed by the nation.

The training by our institutions of the new kinds of health professionals, needed by our nation can be maintained if the new legislation authorized support for institutions which would enhance their capability to meet the nation's health manpower needs, including the need for primary care physicians in underserved rural and urban communities.

Through a joint venture with the federal government we seek an investment to help us train the kinds of physicians needed for the 1980's. This joint venture would signal a national commitment to adequate health care for all Americans, and access to a career in the health professions for all of our youth.

Present data indicate a dilemma for the nation, to overcome deficiencies in minority health professions manpower, while there is an alleged oversupply of non-minority health professionals. There is no oversupply of minority health professionals. Rather, there is a serious deficiency of minority health professionals, which represents a national crisis.

The facts are contained in the following tables.

TABLE I

BLACK ENROLLMENT IN FIRST-YEAR CLASSES IN U.S. MEDICAL SCHOOLS

(1971-1980)

YEAR	NUMBER AND PERCENT OF ENROLLMENT	TOTAL FIRST YEAR ENROLLMENT
1971-72	882 7.1	12,261
1972-73	957 7.0	13,677
1973-74	1,027 7.3	14,154
1974-75	1,106 7.5	14,763
1975-76	1,036 6.8	15,295
1976-77	1,040 6.7	15,613
1977-78	1,085 6.7	16,136
1978-79	1,064 6.4	16,530
1979-80	1,108 6.5	16,930
1980-81	1,128 6.6	17,186

SOURCE: DATA FROM PUBLICATIONS OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ONE DUPONT CIRCLE, WASHINGTON, D.C. 20036

TABLE II

MINORITY STUDENTS IN FIRST YEAR OF DENTAL SCHOOL

ACADEMIC YEARS 1971-71 THROUGH 1978-79 1/

Racial/ethnic category

Academic Year	Total First Year Students	Black	Native American	Mexican-American	Puerto Rican	Asian American	Other Minority	Total Minority	Percentage Minority first-year Students
1971-72	4,705	245(5.2%)	4	27	13	112(2.4%)	11	412	8.8
1971-73	5,287	266(5.0%)	5	53	3	138(2.6%)	10	475	9.0
1973-74	5,389	273(5.3%)	12	64	5	141(2.6%)	34	529	9.8
1974-75	5,555	279(5.2%)	12	68	7	142(2.5%)	43	551	9.9
1975-76	5,697	298(5.2%)	22	64	11	186(3.2%)	56	637	11.2
1976-77	5,869	291(5.0%)	21	81	15	174(3.0%)	68	650	11.1
1977-78	5,390	296(5.0%)	10	2/	2/	225(3.8%)	2/	641	10.9
1978-79	6,301	280(4.4%)	15	122*		263(4.2%)		681	10.8

1/ Excludes University of Puerto Rico.

2/ The data for 1977-78 differ from earlier years because of changes in racial/ethnic categories used for data collection. In 1977-78 there were 110 first-year students under a new category "Hispanic". Also, the former category "Other Minority" was eliminated.

* Hispanic including Puerto Ricans in U.S. Schools.

NB Blacks = 11.6% of total U.S. population. Hispanics = 5.6% and Asians (all types) = 0.9%

Source: AMERICAN DENTAL ASSOCIATION, COUNCIL ON DENTAL EDUCATION. MINORITY STUDENT ENROLLMENT AND OPPORTUNITIES IN U.S. DENTAL SCHOOLS, FOR 1971-72 AND FOR 1972-73. MINORITY REPORT: SUPPLEMENT OF ANNUAL REPORT ON DENTAL EDUCATION 1973-74, AND REPORTS FOR SUBSEQUENT ACADEMIC YEARS. CENSUS OF POPULATION PART 1, U.S. SUMMARY 1970. BUREAU OF THE CENSUS POPULATION PROFILE OF THE UNITED STATES: 1978.

TABLE III

Minority Undergraduate Enrollment in Schools and Colleges of Pharmacy
Academic Years 1971-1972 through 1979-1980

Year	Total Enrollment	Racial/Ethnic Category					Foreign
		Blacks	#	Hispanics	Native Americans	Asian Americans	
1971-72	16,476	618(3.7%)	--	203(1.2%)	8 --	816(4.9%)	-- --
1972-73	18,445	659(3.6%)	372	254(1.4%)	29(0.1%)	720(3.9%)	488(2.6%)
1973-74	20,830	619(3.0%)	314	353(1.7%)	25(0.1%)	697(3.3%)	788(3.7%)
1974-75	22,688	727(3.2%)	377	278(1.2%)	32(0.1%)	690(3.0%)	1,062(4.6%)
1975-76	23,836	915(3.8%)	470	359(1.5%)	36(0.2%)	799(3.2%)	1,006(4.3%)
1976-77	23,465	938(4.0%)	481	353(1.5%)	37(0.2%)	761(3.2%)	824(3.5%)
1977-78	23,273	984(4.2%)	533	360(1.5%)	39(0.2%)	809(3.4%)	810(3.5%)
1978-79	23,078	942(4.1%)	457	376(1.6%)	34(0.1%)	911(3.4%)	707(3.1%)

Source: American Journal of Pharmacy Education 1980

*Total number enrolled in the traditionally black colleges and Schools of Pharmacy

TABLE IV
NATIONAL MINORITY HEALTH PROFESSIONALS

HEALTH PROFESSIONALS	TOTAL	BLACK/%	PARITY	NEEDED/%	BLACK/BLACK POPULATION	WHITE/WHITE POPULATION
Physicians	348,443	5,106/1.7	41,813	35,707/10.3	1:4,001	1:540
Dentists	125,000	2,780/2.2	14,405	11,625/9.3	1:8,785	1:1,510
Optometrists	24,242	186/0.7	2,909	2,723/11.3	1:49,951	1:7,695
Pharmacists	122,500	2,501/2.0	14,700	12,199/10.0	1:11,151	1:1,542
Podiatrists	8,500	400/4.7	978	578/6.8	1:610,87	1:22,800
Osteopaths	17,960	325/1.8	2,065	1,742/9.7	1:75,184	1:10,490
Veterinarians	36,000	252/0.7	4,320	4,068/11.3	1:110,678	1:5,179

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Data from: MINORITIES AND WOMEN IN THE HEALTH FIELDS, SEPTEMBER, 1975; HEALTH MANPOWER

REFERENCES: AND HEALTH RESOURCES AND UTILIZATION STATISTICS 1976; NATIONAL CENTER

FOR HEALTH STATISTICS: A REPORT TO THE PRESIDENT AND CONGRESS ON THE STATUS OF HEALTH

PROFESSIONS PERSONNEL IN THE U.S., 1978; PUBLICATIONS FROM DHHS, AND THE NATIONAL PODIATRY

ASSOCIATION.

Poor and disadvantaged Americans, including our minority citizens, should not have their legitimate and serious needs for more health professionals submerged in the controversy concerning the overall health manpower projections of the Department of Health and Human Services (DHHS).

Health manpower shortages in poor and disadvantaged communities have contributed to an array of serious health problems in our rural and inner city communities of the nation: for example, a shortened life expectancy for blacks (some 6-8 years less than for whites); higher infant mortality rates; a twofold greater incidence of high blood pressure; and many other alarming statistics.

The institutions of the Association are working diligently to supply needed health manpower for our nation.

A fraction of the graduates of all health professions schools go into under-served areas and into primary care careers.

We therefore propose that all health professions schools receive institutional support based upon a percentage of the cost of education in that particular health profession.

We further propose that incentive awards be given to health professions schools which respond specifically to identified national priority needs, as listed above.

B. Financial Distress Grants

Mr. Chairman, section 221 of HR 2004, which deals with Start-up, Financial Distress, Interdisciplinary Training and Curriculum Grants is of great interest to us. This is a most critical section, affecting the survival of our institutions and the maintenance of quality educational programs.

Several of us have participated in the Health Manpower Program since its inception in 1963. We are in financial distress now, and will be in financial distress in the future, unless significant help is acquired. With mounting inflation, there is increased necessity to maintain and to improve our educational base in order to remain accredited institutions; and, in view of higher expectations and demands among minorities and the disadvantaged for access to health professions careers, we find ourselves in the untenable position in which income from traditional sources (tuition, endowment, fund-raising, etc) is simply not sufficient. Reduced funding and rising costs have created financial hardships which none of us can fend off. We have addressed these issues to the various constituencies who have traditionally supported us: alumni, state legislatures and the general public, through fund-raising programs. They have each responded in significant measure but more needs to be done.

Our situation is critical!

The support of the federal government in these institutions is a good investment to meet a national need.

We commend and applaud the Subcommittee's recognition and support of the concept of financial distress programs to assist institutions in danger of loss of accreditation or subversion of quality educational programs.

We recommend two actions:

1. That specificity be given to the amount authorized for each segment of this Section;

2. That language be included to recognize two levels of financial distress of various institutions and to deal with these needs differentially.

C. Student Assistance

Mr. Chairman, we are concerned about the increasing number of low and middle income students who cannot afford a health sciences education. We have historically sought out and encouraged young people to develop their talents and to acquire needed skills. These skills are being used to improve the quality of life for all Americans. Yet, the economics of the 1980s could force our institutions to seek only those students who could afford to pay from their own resources for graduate and professional education. Therefore, we support a student financial assistance program that would maintain the democratic concept of choice.

A student financial need profile was presented by member institutions of the Association to the Subcommittee on Health and the Environment of the House Committee on Interstate and Foreign Commerce, Houston, Texas, October 5, 1979 and again on March 21, 1980. The student financial need profile reflects the following:

Meharry Medical College - "In keeping with this historic and unique mission the college enrolls more disadvantaged students than any other medical school in the United States. Some 86 percent of our student body requests and receives financial aid to help them pay tuition and other expenses."

School of Medicine at Morehouse College - "Seventeen of the students in the Charter Class (24 students) were recipients of National Health Service Corp Scholarships, one was the recipient of an Exceptional Need Scholarship, another was the recipient of an Armed Forces Health Professions Scholarship. Three of the remaining students received scholarships and loans from various private sources, including medical school funds."

Xavier University of Louisiana School of Pharmacy - "Our current tuition rate of \$3,000 per year is below the national average of \$3,100 for private schools of pharmacy, but the economic status of our students is proportionately far lower than that of their peers in other institutions."

Given the financial need profiles of students enrolled in the institutions of our Association, an effective student assistance program is needed. We support the National Health Service Scholarship Program and urge its continuation.

We urge that the Exceptional Financial Need Scholarship program be extended to include second year students in addition to first year students.

We recommend that interest subsidies be provided for loans to needy students in order that these students have a more reasonable fixed financial liability.

D. The Health Careers Opportunity Program (HCOP)

New Health Manpower legislation should insure that the Health Careers Opportunity Program is upgraded and expanded. This program is a significant vehicle through which federal grants and contracts are made to health professions schools to assist young people who are socially, economically, and educationally disadvantaged enter the health professions.

In addition to the on-going commitment of those institutions that have traditionally prepared disadvantaged students for careers in the health professions, there is increasing interest by many

other institutions and community-based organizations in developing programs to identify, recruit and retain disadvantaged students.

The focus of these programs is being broadened to more fully serve native Americans, in addition to blacks, Hispanics and other disadvantaged persons.

The Association believes, however, that 80% of these grants should be awarded to degree-granting institutions. These institutions have proven that they can carry out the HCOP mission in a more cost-effective manner.

For this program, we recommend authorizations of \$40,000,000 for FY 82, \$44,000,000 for FY 83 and \$48,000,000 for FY 84.

E. Facilities

In the past, the Congress has authorized grants for the construction of new facilities at health professions schools. It is now believed that the need for additional health manpower has been met and thus, additional facilities are not needed. However, for minorities, the facts do not support this belief. Tables I, II, and III indicate that the goals for the development of minority health manpower have not been met. In order that the institutions in the Association for Minority Health Professions Schools obtain and maintain their accreditation, facilities of acceptable standards must be constructed. Funds for facilities at these new and developing institutions are needed.

We are pleased that the Subcommittee has included a section in HR 2004 for the construction of medical education facilities, to assist new two year schools in the development of those facilities

required for them to become four year schools of medicine.

For grants under this section we support the authorization of \$15,000,000 for the fiscal year ending September 30, 1982, to remain available until expended.

We recommend that in considering applications for grants under this section, the Secretary give just consideration to applications submitted by two year medical schools which have a high percentage of disadvantaged students.

F. Conversion Projects

To develop educational programs of quality in the health sciences, it is essential that clinical experiences be provided. Since 1973, the Liaison Committee on Medical Education (LCME) has required, as a condition for accreditation, that new two year schools develop into M.D. degree granting institutions.

Conversion support would assist the School of Medicine at Morehouse College in its plan to develop into a four year, M.D. degree granting institution.

We are pleased that the Subcommittee has included the authorization of conversion support for new two year schools of medicine to help them meet the requirement of the LCME that they become M.D. degree granting institutions. However, we recommend that the amount of such a grant to a school be increased to \$50,000 for each third-year student.

We further recommend that, upon request of a school, a grant received under this section may be used in the year preceding the initial enrollment of third year students in such a school.

Conversion assistance from the Federal Government has been established in previous health manpower bills, and has supported the conversion of two year schools to degree granting institutions.

In summary, we urge the following:

1. The enactment of authority for institutional support to assist health professional schools meet national priority needs.
2. That "Financial Distress grants" be enacted with two kinds of financial assistance awards as recommended in this testimony.
3. The enactment of improved student assistance provisions.
4. The enactment of an improved Health Careers Opportunity Program
5. The inclusion of an authority for construction grants for existing new two year schools of medicine.
6. The inclusion of an authority for "Conversion Projects" to assist new two year schools to develop into degree granting programs, as required for continued accreditation.

We thank you for the opportunity to present to this Committee vital issues concerning the health manpower needs of the nation. These legislative measures supported by the Association of Minority Health Professions Schools, if enacted, will enable our institutions to continue their service to the nation, in meeting national priority needs.

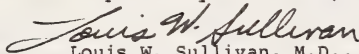
The Future

Chairman Waxman and members of the Committee, the critical shortage of minority health professionals continues to be a national problem, which requires a national solution. The members of the Association of Minority Health Professions Schools are in the forefront of health professions institutions which are addressing this issue in a significant way.

For the ultimate success of this partnership between the Congress and our minority health professions institutions, an ongoing dialogue is required. We look forward to the opportunity for such a dialogue between this Committee and the Association of Minority Health Professions Schools. The decade of the 1970's witnessed significant increases in the number of minority health professionals, but the national goals which were set were not reached.

The decade of the 1980's presents us with a new opportunity to address this challenge. Federal support for the training of needed health professionals from minority and disadvantaged backgrounds must not be compromised. There is still much unfinished business on our national agenda to assure equality of opportunity for minorities in the health professions and to provide equal access to health care for our poor and disadvantaged citizens. Such efforts, to improve the health status of our poor and minority citizens, and to keep alive the American dream of equal opportunity are as important today as they were yesterday. Indeed, a healthy citizenry, with a continuing belief in the American dream is of prime importance in our efforts to maintain a strong republic, and to keep our position of leadership among the nations of the world.

Respectfully submitted,



Louis W. Sullivan, M.D.,
Dean and Director
School of Medicine at Morehouse
College

and
President, Association of Minority
Health Professions Schools

Mr. WAXMAN. Thank you very much, Dr. Sullivan and Dr. Elliott. I want to commend both of you on your testimony today. I think you have made an excellent presentation and a very thoughtful one.

Congressman Leland who has a special interest in this area had to chair his own subcommittee this morning and he also would like you to respond to some written questions.

Mr. Madigan, do you have any comments or questions?

Mr. MADIGAN. Mr. Chairman, in view of the circumstances that we have been running into in the last few days with the extraordinary number of witnesses who want to come before us and talk about these programs that are expiring and are due to be renewed, I think it is incumbent upon all of us to limit our questioning to the degree that we can so that the witnesses all have an opportunity to testify.

So I am going to submit my questions in writing to you gentlemen as well.

If I may do this to set a tone or perhaps to establish a frame of reference for you as to what I think the future is going to bring, with regard to these particular bills I note that the difference between the President's proposal and Chairman Waxman's proposal in the outyears of the authorization gets to be about 100 percent. Mr. Waxman's would authorize about twice as much money as the President proposes to authorize.

The President has told me this morning that if it is necessary to use the veto he is going to use the veto to reduce the level of government activity in our society. I think that we need to make a commitment to make better use of a limited amount of money.

In that regard I think it is important for you to understand the minority of this subcommittee is interested in working with all of the interest groups to make better use of a limited amount of money and we will be happy to have a continuing dialog with you in that regard.

Thank you very much.

Mr. WAXMAN. Thank you, Mr. Madigan.

I might point out that the bill that I introduced was the bill that this subcommittee and the House overwhelmingly adopted last year. That is our starting point for discussions. This is a different Congress facing a different political climate than we faced in the last Congress so we will all want to work together and see what we can do to keep the commitments we have made in the past and use what resources we are able to use as efficiently as possible.

Mr. Shelby.

Mr. SHELBY. Thank you, Mr. Chairman.

I will be brief in keeping with what we are trying to do because you have got a big schedule this year.

Dr. Elliott, I was particularly interested in some of the past things you have done, that is in the Florida area, your program in medical sciences, the joint venture between Florida A. & M., Florida State and the University of Florida in trying to, what, get them together on the first year of a medical school?

Dr. ELLIOTT. I could describe that very briefly. It is a first-year medical school program but it takes place in Tallahassee in conjunction with Florida A. & M. and Florida State. What it does is

create time flexibility by mixing the first year of medical school with the undergraduate program so that students of differing backgrounds can come up to a common level before they transfer to the clinical portion of the medical school at Gainesville and it works very effectively.

Mr. SHELBY. I like what you are doing there because you are doing what the gentleman from Illinois, Mr. Madigan, I thought stated as to the better use of a limited amount of money. You are doing this and you are going to have to do this. Let's don't kid ourselves.

Are they doing anything like that in Alabama? I know I have a dean here from Tuskegee Institute who is the dean of the veterinarian school there. I would be interested in whether they are doing it in other States because it is a better utilization.

If you are going out and you are going to increase the minority doctors, and we need that, and I know you advocate it, I think that statistics have shown that they do go into the underserved areas. They go back to serve people that need to be served, the underserved.

Couldn't you go out a step further and spot a lot of the minority children who have propensities in the science field in the eighth or ninth grade and bring them into some type of accelerated program? Wouldn't that help get them ready for a medical school? A lot of them are being denied entrance into medical schools and vet schools because maybe they hadn't come up to a level. Isn't this what you are trying to do in Tallahassee?

Dr. ELLIOTT. Yes, certainly, although we do it to a fairly limited degree at the college level. I think one of the positive aspects of the legislation as regards the education of minorities and disadvantaged is the health careers opportunity program which does attempt to tie it together.

I see an increasing involvement of the health professions schools in their communities. I use Texas Southern as an example because they have some exciting work going on in the middle of Houston; I refer also to community based operations like Espira for Puerto Rican students and like La Raza in California for Chicano students. There are various groups that are working hard to increase the number of students interested in health professions.

Mr. SHELBY. Well, couldn't you take it a step back to the seventh and eighth grades and you spot these children that have different aptitudes? All of us know, whether they are minority or not, there are some students that have a propensity to just gobble up math and science and others do not.

Dr. ELLIOTT. Yes, I think it is possible.

Mr. SHELBY. That would be a better utilization of money, would it not?

Dr. ELLIOTT. I think it would be one good utilization of the money, yes, sir.

Mr. SHELBY. Thank you.

Dr. SULLIVAN. Mr. Shelby, if I could also respond.

Mr. SHELBY. Yes, Mr. Sullivan.

Dr. SULLIVAN. I believe all of the institutions in the Association of Minority Health Professions Schools have programs of varying degrees. The Texas Southern program is one that certainly is very

successful. Morehouse has such a program, Meharry and I believe the other schools as well.

What has happened in the past in terms of reaching down into the schools is that the limited resources which have been available for the HCOP program have really been targeted more toward the upper levels in high schools and in colleges.

Certainly I would agree with you that to go back down, we certainly would see that as a very effective way to help address the problem.

Mr. SHELBY. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Bliley?

Mr. BLILEY. No questions.

Mr. WAXMAN. Ms. Mikulski?

Ms. MIKULSKI. Thank you very much.

My question would be directed to either of the two panelists.

In terms of minority students or disadvantaged students being able to pursue careers in health sciences, pharmacy, medicine, and nursing, is the major problem for a student wanting to attend those schools the kind of preparatory educational training that goes into it or is it money, family income?

Dr. SULLIVAN. Yes, the primary problem is money. We have no dirth of applicants to our institutions. We believe, however, that it is not exclusive. Certainly efforts need to be addressed to increase the size of the minority applicant pool. But the reality is that the family income of minority students in medical schools is approximately half of that of the family income of while students in medical schools.

Ms. MIKULSKI. Dr. Sullivan, what is that family income average? Could you share that with us, please.

Dr. SULLIVAN. Yes. It is approximately \$14,000 for the average family income of a minority student as compared with approximately \$27,000 for the average majority student.

Ms. MIKULSKI. So that for the minority students applying, for example, at Morehouse or some of the other schools outlined here, their family income is equivalent to, say, what 1 year's tuition might be at Georgetown?

Dr. SULLIVAN. That is correct.

Ms. MIKULSKI. Now, in terms of the money for tuition and other expenses to be able to attend a medical school or a nursing school, how do we target our resources so we do not create false expectations for the student or a burden which we only meet half way, knowing that the strains of a medical education in and of itself are enormous?

Is it the tuition, is it the books, is it living expenses? In other words, is a loan program enough? Is a tutition program enough? Or do we need to think about it in different ways?

We have several programs like the exceptional financial need for first year students. To me, if you are poor in the first year you are going to be poorer in the second year, and given the way the expenses are going you will even be poorer in the third year.

I am just wondering how you would structure a program that would enable a student to give full-time attention to his or her educational pursuits?

Dr. SULLIVAN. This is a serious problem, Representative Mikulski. We believe that student assistance programs really need to have a variety of approaches. Some students find the National Health Service Corps Scholarship program a very useful, convenient and acceptable vehicle because they are committed to working in underserved areas. Loan programs for some students are acceptable.

The problem that does exist is that a student who comes from a family with a family income of \$10,000 or \$15,000 dollars finds it very difficult to conceive of going into debt for \$40, \$50 or \$80 thousand which is a reality that many students face. Also, the high interest rates that students have to pay if loan subsidies were discontinued would also be a great disincentive for students considering health careers.

So we believe that a mix of scholarship support, loan support, service contingent loans as well as the National Health Service Corps is needed if low-income students are to have access to a health career because there are other family needs that of course must be met with that \$10,000 or \$15,000 income.

Ms. MIKULSKI. Two other questions, which you might want to think about and respond in writing after consultation with members of the association.

It is tough to be poor and try to become a doctor or a nurse, or a veterinarian or a pharmacist.

My question would be, are there any segments of the curriculum that could be structured in a way that students could pursue a work-study program at certain parts of their education where the emphasis is primarily on academic work rather than clinical work? In other words, in the first part where there is actually a structured time schedule, are there opportunities where, through work-study, they could be picking up a few bucks as well as pursuing their education, thus alleviating part of the burden and in some way the role that the government would play in that? Has that been explored?

Dr. ELLIOTT. Unfortunately most professional schools tend to fill their curricula very heavily. It used to be feasible 15 or 20 years ago, for a medical student to work part time. It has not been so in recent years. I could not answer for other health professional schools.

Ms. MIKULSKI. Well, is there anything magic about having to finish medical school in 4 years?

Dr. SULLIVAN. No, there is not.

Ms. MIKULSKI. Particularly if you can pay your bills for 6 years, but you can't pay them if you are going for 4.

Dr. ELLIOTT. I would say that time flexibility is one of the advantages of the type of program we created in Tallahassee. The student can accelerate or decelerate according to his or her needs, academic, financial, and other needs.

Ms. MIKULSKI. Who could I talk to about these innovative curriculum structures that deal with the financial issues?

Dr. SULLIVAN. There are several curricula that address this problem but not to my knowledge from the standpoint of work-study. Dr. Elliott's program is certainly one. At Morehouse we have flexibility that our students, for example, can do the first 2 years of

medical school in 3. Boston University has a program, their so-called medic program, that also stretches from the sophomore year of college through medical school in an integrated fashion.

The purpose of that program that I am somewhat familiar with because I was on the faculty there prior to my present position, the purpose of the program there has been to relieve some of the pressures of the academic process as opposed to work-study.

Ms. MIKULSKI. Thank you very much.

Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Benedict, do you have any questions?

Mr. BENEDICT. I might offer an observation, if I might, please, Mr. Chairman. I have no questions.

It seems to me that last week when we heard testimony about this education of health professionals that we heard very convincing arguments that this country is rapidly in overall terms reaching an appropriate or an acceptable level of health professionals to meet our society's needs but that there was still existing a significant part of our population where we were not meeting the needs. That was in the long-term poor and the lower end of the economic scale and also related to minorities I think.

It seems to me that given the time of limited resources as we are that it would be appropriate for us in considering this legislation to focus as tightly as possible in an area where we might have a chance of improving the number of minorities in the health professions and thereby perhaps have a hope of meeting these needs of folks that we have not been touching.

I think there was a thread of that in testimony last week and I think that that is something that we as a committee ought to consider in focusing on how we can use limited dollars to advance a solution perhaps of a problem that we have not yet touched.

Dr. ELLIOTT. Our testimony is that the most effective use of dollars in terms of health manpower would be to keep the HCOP and the health minority professions school support because within the limited resources it is more likely to affect positively the health care for underserved populations in various ways.

Mr. BENEDICT. Correct.

Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Luken, any comments or questions?

Mr. LUKEN. I have nothing at this time, Mr. Chairman.

Mr. WAXMAN. I might point out that the Reagan administration recommendations on the disadvantaged program and on financial distress is to keep the present level of funding.

Dr. ELLIOTT. It is within the President's agenda, that is correct.

Mr. WAXMAN. They do recommend lowering amounts on the student aid but on these two programs they are recommending the same amount.

Well, thank you very much, both of you.

Dr. ELLIOTT. We will look forward to answering your questions in writing. Thank you for the time.

Dr. SULLIVAN. Thank you, Mr. Chairman and members of the committee.

[Mr. Leland's questions and responses thereto follow:]

CONGRESSMAN LELAND'S QUESTIONS AND MR. SULLIVAN'S RESPONSES

QUESTION # 1: What is the appropriate role for the federal government, during this time of fiscal constraint, in addressing the needs of the poor and minority students who wish to pursue a career in the health professions?

Allow me to answer that question in two parts. First, should the federal government play a role in addressing the needs of the poor and minority students who wish to pursue a career in the health professions? Yes, the federal government should play a role. Minority students are underrepresented in all health professions, and it is essential that the federal government take action to increase minority representation. Currently Blacks are 1.3% of all veterinarians, 1.7% of all physicians, 1.8% of all dentists, and 2.0% of all pharmacists. These figures fall well below the incidence of Blacks in the population at large, 12.8%.

What is the appropriate role for the federal government to take? It should take two approaches, assisting the minority students and assisting the schools training minority students. The federal government may assist students through federally financial aid programs. It may provide institutional support to the schools who are in the forefront preparing minority students for health careers.

QUESTION # 2: What is the rationale for the federal government to support your schools over all other health professions schools?

There are four reasons. First, the schools are in financial distress, and they urgently need federal funds. Second, the schools receive limited state support. For example, this year only 10% of the Tuskegee Institute Veterinary School budget is from the State of Alabama. Third, the schools are a national resource. Their students come from across the country, and their alumni practice in virtually all states. Fourth, the records of these schools in training minority health professionals is unprecedented. Association schools have graduated 50% of the Black pharmacists, 90% of the Black veterinarians, and 43% of the Black physicians and dentists.

Percent of Budget From State Funds

Morehouse - 50%

Florida A & M University - 50%

Texas Southern - 69%

Xavier - 2% (in financial distress)

Meharry - none (in financial distress)

QUESTION # 2 (Cont'd)

Ratio of Total Students to Minority Students

Tuskegee: 2% of veterinary students

43% of minorities

Meharry: 8% of medical students

10% of minorities

9% of dental students

15% of minorities

Xavier:

11% of Black students

QUESTION #3: What are the minority/caucasian enrollments in your school?

Tuskegee Institute:	Minority:	143	66%
	Caucasian:	73	34%
	Total:	216	100%
Meharry University: Medical School	Minority:	479	92%
	Caucasian:	40	8%
	Total:	519	100%
Meharry University School of Dentistry	Minority:	212	97%
	Caucasian:	7	3%
	Total:	219	100%
Xavier University	Minority:	152	80%
	Caucasian:	37	20%
	Total:	189	100%
Florida A&M University	Minority:	254	77%
	Caucasian:	60	23%
	Total:	314	100%
Texas Southern University	Minority:	326	99%
	Caucasian:	2	1%
	Total:	328	100%
Association Schools	Minority:	1619	88%
	Caucasian:	228	12%
	Total:	1847	100%

QUESTION # 4: Given the high cost of health professions educations, how can we ensure that the graduates of your institutions practice in underserved areas?

Given the freedom to choose where to practice, most of our graduates would probably prefer to practice in the regions of the country from which they were recruited, the health manpower shortage areas. However, graduates saddled with huge educational debts have no choice upon graduation except to pursue lucrative employment in order to retire the debt. Indebtedness prohibits students from choosing to practice in a manpower shortage area. We propose that the federal government fund a low interest loan program for health professionals. A condition of receiving the loan will be agreeing to establish private practice in one of the designated manpower shortage areas. This proposal has several advantages over the National Health Service Corps. First, the practitioner is more likely to remain in the manpower shortage area upon completing the obligation if he or she has invested in private practice. Second, it is cheaper than the National Health Service Corps because it relieves the federal government of paying salaries and related expenses to members of the Corps. Third, by giving the practitioner an option where to practice and the freedom to establish it, the program should be much lower because the practitioner is investing himself in his practice.

QUESTION # 5: What percentage of your students come from low income backgrounds?

How do you provide access to disadvantaged students?

A vast majority of our students come from low income backgrounds. The results of a survey of our students revealed that the median family income is approximately \$15,000.00. This indicates that more than 87% of our students come from families classified as low income.

Morehouse - 94%; Florida A & M - 90%; Texas Southern - 60%;
Xavier - 62%

Tuskegee Institute has a minority recruitment program funded under the Special Health Careers Opportunity Program.

1. We actively recruit in junior and senior high schools and colleges using alumni and faculty.
2. We attend State and National guidance and counselling conferences.
3. We secure financial assistance for students.

QUESTION # 6: What does it cost each of your school's per student per year to educate students, and how are these costs currently being met?

a.	Tuskegee \$16,000/student/year	<u>sources</u>	
		tuition, fees, gifts	12%
		federal	5%
		state, regional	40%
		research, other inc.	31%
		clinics and other	100%
b.	Morehouse \$21,000/student/year	<u>sources</u>	
		local	
		state	50%
		federal	35%
		corporate/foundation	
		tuition	13%
			100%
c.	Florida A&M University \$3,359/student/year	<u>sources</u>	
		state	67%
		tuition	33%
			100%
d.	Texas Southern \$4,900/student/year	<u>sources</u>	
		state	69%
		federal	31%
e.	Meharry Medical School \$21,375/student/year	<u>sources</u>	
		tuition, gifts	35%
		region contracts	6%
		government grants	37%
		other	22%
			100%
f.	Meharry Dental School \$22,585/student/year	<u>sources</u>	
		tuition, fees, gifts	26%
		regional contracts	1%
		government grants	54%
		other	19%
			100%
g.	Xavier School of Pharmacy \$9,501/student/year	<u>sources</u>	
		tuition, fees, gifts	33%
		state capitation	2%
		government grants	64%
		other	1%

QUESTION # 7a: What role do MCAT, VAT scores play in your admissions criteria?

The admissions committees consider the scores, but they keep in mind that for many minority students, aptitude test scores are not always an accurate indicator of a student's ability to do well in school. Aptitude test scores are one of several indicators that we use.

QUESTION # 7b: How do you adequately prepare your students who come from disadvantaged backgrounds for a career in health professions.

Virtually all the schools in the association have implemented academic reinforcement programs, with similar components, summer preparatory programs, faculty and peer tutorial assistance, audio visual and auto-tutorial aids, and course syllabi. In addition, most schools have minority recruitment programs designed to reach potential students as early as junior high school and stimulate their consideration of a health profession. In general, the programs have succeeded in attracting minority students to health professions education who might not have considered it otherwise, and they have succeed in retaining the student in school once he has been admitted.

Mr. WAXMAN. We will hear from representatives from schools and programs that train public health professionals and health administrators.

Mr. Mike Gemmell is the executive director of the Association of Schools of Public Health.

Dr. Steven Sundre is the vice president of the Association of University Programs and Health Administration.

Dr. David Rabin of Georgetown University is from the Association of Teachers of Preventive Medicine.

I would like to welcome these three gentlemen if they will come forward.

Mr. Gemmell, why don't we start with you?

STATEMENTS OF MICHAEL K. GEMMELL, EXECUTIVE DIRECTOR, ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH; STEVEN M. SUNDRE, PH. D., VICE PRESIDENT, ASSOCIATION OF UNIVERSITY PROGRAMS IN HEALTH ADMINISTRATION; AND DAVID RABIN, M.D., PAST PRESIDENT, ASSOCIATION OF TEACHERS OF PREVENTIVE MEDICINE

Mr. GEMMELL. Mr. Chairman, we will be very, very brief. We thank the members for the opportunity to express our views on behalf of the Association of Schools of Public Health which is the only national organization representing 21 U.S. schools of public health.

The main responsibility of our schools is to train men and women to operate this country's public health, disease prevention, and health promotion programs in the Federal, State, and local area.

We look forward to working with the members of the subcommittee in reporting out a bill that seeks to do the following things:

One, provide an adequate supply of health personnel to work in areas of national need such as disease prevention, health promotion, health administration, policy and management, environmental and occupational health, epidemiology, biostatistics, nutrition, and maternal and child health among others.

Two, increase the supply of public health students in under-represented minority groups.

Three, promote the development of curriculum in national priority public health disciplines.

Four, support programs training medical personnel in areas of preventive medicine and dentistry.

Five, upgrade the management skills of executives in health policy management programs.

Finally, to provide institutional support to schools of public health to enable the training of public health specialists in manpower shortage areas.

We believe, Mr. Chairman, that H.R. 2004 addresses these points, especially the last one. The bill provides basic financial institutional and student support for costs incurred by the schools in providing comprehensive training of personnel charged with the responsibility of carrying out Federal, State, and local health programs.

Mr. Chairman, the schools of public health are in the business of training men and women for public service. Our graduates work mainly in the public sector in areas of health promotion and dis-

ease prevention. They represent the basic resource pool from which Federal, State, and local health and environmental health agencies draw their manpower needs.

Graduates also work and teach in university settings. Industry relies heavily on the schools to train their employees involved in industrial hygiene, occupational safety and health, among others.

The breakdown in any given year as to where our graduates go are as follows:

Fifty percent work for tax-supported organizations like in State, local, and Federal health and environmental health agencies.

Thirty-two percent work in university settings, both training other or future public health officials and providing community service in the area.

Twelve percent, approximately, work for industry.

Our schools are no longer primarily involved in training people for State and local health departments because they have broadened their training areas. Our graduates receive modest salaries in contrast to the high remuneration of other health professionals.

For example, a recent survey showed that our 1979 graduates started their new careers or the new job in midcareer at about \$19,000 to \$20,000 a year. After 15 to 20 years experience the average pay for a public health worker is about \$30,000 a year.

So Federal support, institutional support, and student support, is crucial to these men and women in midcareer who have enrolled in the school of public health for 2 years to receive a master's of public health and training in public health areas and then have returned back to the public service.

H.R. 2004, Mr. Chairman, targets financial support to categorical programs that are responsive to national health requirements. The quid pro quo implied in Federal support is based on results in terms of public service commitment of graduates attracted to specialty and geographic areas in need.

Federal support, Mr. Chairman, challenges the schools to place emphasis on Federal priority areas of needs such as health administration, preventive medicine, epidemiology, public health nursing, environmental and occupational health specialists, nutritionists and maternal and child health workers, among others. These people again provide services in disease control, protection against health hazards, health services management, medical cost reduction, health promotion and disease prevention.

In closing, Mr. Chairman, I would like to commend members for holding hearings on these very important health manpower programs.

In the interest of time I would like that our official statement be incorporated in today's record and we look forward to working with you and members of your staff in the future.

[Testimony resumes on p. 319.]

[Mr. Gemmell's prepared statement follows:]

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STATEMENT OF THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH TO THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT OF THE HOUSE COMMITTEE ON ENERGY AND COMMERCE ON H.R. 2004, THE HEALTH PROFESSIONS EDUCATION ASSISTANCE AND NURSE TRAINING AMENDMENTS OF 1981, MARCH /2 1981, WASHINGTON, D.C.

The Association of Schools of Public Health (ASPH)*, which represents all of the twenty-one U.S. Schools of Public Health, appreciates this opportunity to present its views on H.R. 2004, the "Health Professions Educational Assistance and Nurse Training Amendments of 1981". H.R. 2004 is a comprehensive legislative proposal which seeks to accomplish a number of very important goals.

The purpose of this statement is two-fold: one is to make the Congress and this Committee aware of the major training and financial problems facing Schools of Public Health today; and two is to clearly spell out the ASPH position on the Federal role in public health professions educational assistance programs.

Public health deals with the protection and improvement of community health by organized community effort. Public health activities are essentially a public or government responsibility. The services of public health agencies are not reimbursable on a fee-for-service basis as are personal health services. Rather than treating the symptoms of disease in one person, public health is concerned with discovering how a disease occurs, in halting its spread and in organizing programs for those who have been or may be affected by it in a community, state or a nation. The goal in theory and in practice is to discover the source of ill health and to reduce or eliminate it at the earliest point. As a public responsibility such preventive activities have been largely supported by public funds.

*ASPH is the only national organization representing the Deans, faculty and students of the twenty-one Schools of Public Health. The Schools represent the primary education system that trains personnel needed to operate our Nation's public health, disease prevention and health promotion programs. ASPH's principal purpose is to promote and improve the education and training of professional public health personnel.

Public health measures have been successful in controlling communicable diseases as a major cause of death in the United States. While these measures should continue to prevent a resurgence, today the major public health problems in this country involve the causes and control of chronic diseases such as cancer and heart disease; the control or elimination of environmental health hazards; and the provision of equal access to quality health care at reasonable costs.

In recent years Congress has addressed these problems through significant legislation dealing with environmental health, disease prevention and planning, evaluation and management of the health care delivery system. Such legislation has created growing manpower needs in public health. The demand is expected to continue and increase as new programs to improve the quality of life and reduce health care costs are enacted, yet Federal support has actually declined since the mid-1960's (See Table I and Attachment A).

Few studies have been conducted on the impact of the new legislative initiatives on the demand for public health manpower. A study conducted in 1973, prior to the enactment of the health planning law and the current emphasis on cost containment, showed a short fall in every category of professional public health manpower:

U.S. Estimated Supply of and Requirements for Selected Categories of Professional Public Health Manpower*

Occupational Category	Professionals with masters level training or higher			
	Base Year Supply (1970 unless specified)	1980 Supply, assuming Constant School Output	Reduced School Output	Possible 1980 Requirements
Environmental Health	2,200	4,300	3,800	5,000
Epidemiology	1,000	1,800	1,500	2,000
Health Education	2,000	3,600	3,100	6,000
Health Services Administration	8,500	18,200	15,300	25,200
Health Statistics	1,100	1,700	1,500	2,500
Maternal Health, Family Planning & Child Health	800	1,800	1,500	2,000
Mental Health	200	400	350	1,100
Public Health Dentistry	300	550	500	550
Public Health Nursing	2,457	5,200	4,500	5,700
Public Health Nutrition	1,000	1,800	1,500	2,600
Public Health Veterinary Medicine	200	350	300	550

*Department of Health Administration, School of Public Health, University of North Carolina. Professional Health Manpower for Community Health Programs, Chapel Hill, North Carolina, 1973.

The Schools of Public Health are the major manpower training resources available to meet the increasing demand for highly trained and competent personnel in the public health field.

Federal health professional manpower policy has focused almost exclusively on physicians and has based policy decisions affecting other health professions on conclusions relating to physicians. For example, studies have shown that there may be a substantial oversupply of physicians around 1990. Based on this finding the President's FY 1981 budget request assumes an oversupply of all health professionals and consequently targets its request for health professions education programs at minimizing the future oversupply of health professionals. As suggested by the chart, the available evidence indicates an undersupply of public health personnel. Also the recent Surgeon General's report (Healthy People) found that there is a need for prevention manpower especially in the fields of epidemiology, biostatistics, health administration, environmental health, occupational safety and health, nutrition, among others. Further, a December 1979 HHS report to Congress on community and public health personnel also called for increased federal support to programs training professionals in these priority public health areas.

The Schools of Public Health* have been educating professionals in the techniques of public health practice, health preservation, health promotion and disease prevention and control since the first decades of the twentieth century. Some Schools of Public Health had their beginnings in university schools of medicine; others were conceived from the outset as autonomous units within their parent institutions. Today there are twenty-one fully accredited Schools of Public Health in the United States, 7 at private and 14 at public universities.

Schools of Public Health are distinct from other health professions schools in a number of ways. They are oriented to the community and prevention rather than to the individual and cure. They train people in a value system that is egalitarian and public service oriented. They train persons to be need oriented rather than demand oriented. They teach techniques of need response and how to view the "community as a patient". Students are prepared for community teamwork and administration rather than private practice. To solve community health problems the typical graduate works on a team in organized community action, deals with administrative problems and must understand group behavior as well as health care techniques.

Located in 17 states and Puerto Rico, the 21 accredited Schools of Public Health train students from every state in the nation. The Schools have a combined enrollment of over 7,000 students and a faculty in excess of 1,700.** Graduate education in the 21 Schools is organized around a number of major specialties.

*University of Alabama in Birmingham, University of California-Berkeley, University of California-Los Angeles, Columbia University, Harvard University, University of Hawaii, University of Illinois, The Johns Hopkins University, University of Loma Linda, University of Massachusetts, University of Michigan, University of Minnesota, University of North Carolina, University of Oklahoma, University of Pittsburgh, University of Puerto Rico, University of South Carolina, University of Texas at Houston, Tulane University, University of Washington and Yale University. Boston University and San Diego State University will be seeking accreditation in the Fall of 1980 and 1981, respectively.

**When federal support for Schools of Public Health began in the late 1950s, 11 Schools were training 2,000 students. Federal support has remained constant since the early 1970s. In constant dollars, Federal support has declined drastically

(See Table I and Attachment A)

Some of the fields of concentration offered by the Schools are:

- Behavioral and Social Sciences
- Biostatistics
- Environmental Health Sciences
- Epidemiology
- Health Services Administration,
- Policy & Management
- Health Education
- International Health
- Maternal & Child Health
- Nutrition
- Occupational Health & Safety
- Population Studies
- Public Health Practice & Program
- Management (e.g., public health nursing)

Graduates of the Schools of Public Health work primarily in the public sector in the areas of health promotion and disease prevention. They represent the basic resource pool from which Federal, state and local health and environmental agencies draw their manpower needs. Graduates also work and teach in university settings. Industry relies heavily on the Schools to train their employees involved in industrial hygiene, occupational safety and health, environmental toxicology, among others. The breakdown is as follows: 50 percent of graduates in a single given year go into federal, state or local government service, 34 percent work for either non-profit community health agencies or universities and 4 percent work for industry.

ASPH data shows that the Schools no longer primarily train professionals for state and local government agencies. In response to a demand for new types of health workers and a broader concept of public health, the Schools have made major efforts to train students in health services administration and epidemiology, now the two most frequently chosen areas of specialization. Health services administration attracted 1,923 students in 1979-80, or 26.1 percent of the total. With health planning and policy studies counted in, that total would be even higher. Epidemiology narrowly displaced environmental health/sciences as the second most frequently chosen specialty. Environmental health/sciences ranked third with 900 students in 1979-80 (12.2 percent), while "other" areas of specialization was fourth with 827 students (11.2 percent) and public health practice and program management ranked fifth with 651 students (8.8 percent).

Students who attend the Schools are often mid-career professionals with a prior commitment to public service. The average age is slightly over 30. A large percentage are part-time students already working in the public sector while upgrading their skills. It should be noted that a public health degree does not increase the income potential of the graduate as much as other health professions degrees. Schools of Public Health are in the business of training men and women for public service.

The 21 accredited Schools are two-thirds state owned and one-third privately owned. In FY 1974, less than one percent (0.9) of total state expenditures for support of health manpower training institutions went to public health.* The

lion's share (64.5 percent) went to the training of physicians. None of the private institutions, except the University of Pittsburgh, receives state support. Private Schools by and large depend on the traditional means of private sector support such as endowments, tuition, gifts, etc., yet they are in the business of training workers for the public sector.

FEDERAL ASSISTANCE TO SCHOOLS OF PUBLIC HEALTH

I. Institutional Support

Federal assistance to encourage development of experienced public health professionals began with traineeship support in 1956, thus making federal aid to Schools of Public Health one of the oldest health manpower training programs. Federal institutional support was authorized in 1958 and the special project grants program began in 1960. Since the Federal assistance program began, the number of accredited Schools has almost doubled from 11 to 21 and the enrollment has increased fivefold, yet Federal support has remained constant since 1975. In current dollars, institutional support has declined more than 40 percent since 1970 (See Table II).

The basic intention of Federal institutional support to public health schools is to increase the supply of health manpower in fields where the demand is high and/or where a shortage exists. The July 1979 Surgeon General's Report said that although there is a lack of public health manpower data,* there are definite shortages of certain specialized disciplines such as epidemiologists, biostatisticians, occupational and environmental health workers and health service administrators. The overwhelming majority of these professionals are trained in Schools of Public Health.

Institutional support to both public and private non-profit Schools has provided a general subsidy which may be used for any educational program of the Schools including teaching and community service. Such grants supplement other sources of income and permit a degree of flexibility in program development. For the newer and smaller Schools the institutional subsidy has stimulated growth and provides a measure of financial stability.

Providing basic institutional support is a means whereby the Federal government can share the costs** with states and private institutions for the training of public health personnel to manage and operate governmental health programs.

The Schools still need flexible but accountable funds which they can use to support parts of their overall program which have been weakened by insufficient Federal, state and local and private financing.

Adequate training and research funds are available in certain fields such as toxicology, nutrition, occupational safety and health to partially support students and to purchase supplies and equipment. However, there are no categorical funds available, except the old formula grants and the present capitation grants, that provide adequate support for curriculum development and program support.

ASPH believes that HR 2004 would provide the basic generic support for improving the quality of the curriculum and teaching techniques and enhance the capacity of the Schools to provide health promotion and disease prevention activities in the

*Reasons for the lack of data are several, such as lack of uniform and fixed definitions and requirements for employment, methodological problems and high costs of gathering information.

**Teaching costs per student per year approximate those of medical schools. ASPH estimates that it costs \$10,000 to train one public health student each year.

community.

An alternative to capitation is needed because of the general disfavor of the program. While it has been effective in increasing enrollment, it has not been effective as a means of addressing the problems of specialty and geographic maldistribution. Dealing with these problems requires targeted programs of assistance. Basic institutional support would assure the health care system an adequate supply of public health professionals in defined national priority areas. HR 2004 targets financial support to categorical programs that are responsive to national health requirements and programs. The *quid pro quo* implied in Federal support is based on results in terms of increased minority enrollments, public service commitment of students and graduates attracted to specialty and geographic areas in need. Federal support, in terms of institutional, student, and curriculum assistance, challenges Schools to place emphasis on Federally defined priority areas. It ensures the training of professionals (such as health administrators, biostatisticians, epidemiologists, public health nurses, preventive medicine specialists, environmental and occupational health specialists, nutritionists, maternal and child health workers, among others) who would provide services in disease control, protection against health hazards, health services management, reduction of cost, health promotion as well as disease prevention.

The Administration has proposed the termination of capitation funds for all health professions schools in FY 1981 based on the assumption that capitation grants are incentive payments to Schools to increase their enrollment and are no longer needed since there is or will be an adequate supply of licensed health professionals in the 1980s and 1990s. Yet ASPH studies and two prepared by HHS* point out that the demand for the types of health manpower trained by Schools of Public Health will increase as a result of current and future legislative and Administration initiatives in the fields of disease prevention and health promotion (not to mention improved management of health services delivery). These initiatives are looked upon as means to improve the quality of life and to reduce skyrocketing health care costs.

In view of the growing demand for health manpower stimulated by recent passage of Federal programs such as health planning, clean air, clean water, toxic substances, health maintenance organizations, older Americans act, nutrition programs, PSROs, and other federal initiatives such as home health care, child immunizations, mental health, child health, health promotion, rural and urban health initiatives, among others, the ASPH believes that continued institutional support is justified by the nature of public health as a governmental enterprise aimed at the improvement of the public's health. Furthermore, the Schools of Public Health presently represent the major source of supply of trained personnel to implement and manage the Federal health programs and initiatives. Institutional support is simply a partial reimbursement of costs incurred by the Schools in providing comprehensive training of personnel for Federal, state and local governments, industry and voluntary health agencies charged with the responsibility of carrying out Federal programs and meeting Federal health requirements.

In terms of actual percentage that institutional support would represent as part of the federal health budget, the figure (\$8 million) is miniscule. When one examines the percentage these grants will represent in the total operating funds of

*A December 1979 report to Congress on Community and Public Health Personnel and the Surgeon General's Report, Healthy People. Also the Institute of Medicine and NIH have repeatedly stated that a short supply of epidemiologists and biostatisticians exist.

~~Schools of Public Health, however, the percentage will be around 10 percent.~~

The Federal funds received by Schools of Public Health have been considered to be the Federal government's share of preparing public health personnel to meet the needs of public today and for the future. The amounts, while small in comparison to overall expenditures, have and will continue to contribute to the preparation of this vital health resource.

The capacity of the Schools to respond to emerging needs, to offer a balanced curriculum and to provide graduate training in critical areas which are unsupported by other funding sources would be severely reduced by the absence of institutional support. To delete institutional support now or in the near future will diminish the ability of the Schools to serve the Nation's health in the manner intended by those national leaders who first conceived the notion of financial support to Schools of Public Health.

ASPH supports Part E of H.R. 2004 because it provides stable support to the Schools of Public Health. This financial assistance would enable these public health graduate institutions to provide categorical educational programs and community services that are complementary to national public health shortage areas outlined in Healthy People. The quid pro quo implied in Federal assistance would be based on results:

- Increased supply of professionals working in nationally defined specialty shortage areas such as health administration and management, biostatistics, epidemiology, nutrition, gerontology, environmental and occupational health (including toxicology), health promotion, maintenance and disease prevention, among others.
- Increased supply of manpower needed to implement national public health and health care service programs.

The justification for continuing institutional support to students and Schools of Public Health is generally the same as it was 20 years ago when the program first began. Public health schools train personnel for public service. The Federal government has a direct interest in assuring that an adequate supply of public health personnel is trained in quality institutions to manage and operate the health delivery system in the national interest.

ASPH strongly urges the Committee to enact Part E of H.R. 2004. However, the bill should be amended to take into account the fact that requirements to increase student enrollment should be accompanied by adequate support to refurbish, renovate and construct additional facilities to accommodate the increases called for in Section 791(e)(2). Most Schools do not have the resources to adequately serve an increasing student population.

II. Student Assistance (Traineeships)

ASPH strongly urges enactment of Section 792 of H.R. 2004. It provides needed support to students entering or continuing their professional careers in public health.

When the "Health Professions Educational Assistance Act of 1976" was originally passed, Section 748 authorized traineeships for Schools of Public Health alone. Subsequently, it was discovered that preventive medicine and dentistry residencies had been overlooked in drafting the Act. This section was then amended to cover them and to include other public or non-profit institutions providing graduate

training in public health. The authorization level was raised \$1 million for each of the years of authorization to accommodate the expanded eligibility. However, these funds have never been appropriated. For this reason, we strongly support passage of the preventive medicine Section 794(D) of H.R. 2004.

The traineeship program is intended to attract high caliber students and to offer the economically disadvantaged, especially minorities, an entry point into the system. The rising cost of tuition and other expenses will make it even more difficult for low-income students, particularly minorities, to afford graduate education in public health schools. Furthermore, many undertake graduate study in public health at mid-career and have important family obligations. Others have already accrued heavy debts from their previous education. Over 75 percent of students received some form of financial help in 1979-80.

The graduates, unlike many of the other health professions, do not enjoy lucrative incomes. Over 90 percent of the graduates are employed by governmental and community agencies and universities. Their modest salary levels are reflected in a recent survey which showed an average of only \$30,000 after 15 years of experience. Of the 1979 graduates, 57 percent earn less than \$19,000 per year, 17 percent \$19,000 to \$22,000, and 20 percent \$25,000.

Calculated in constant dollars, traineeship support has declined by 48.6 percent since 1970 with enrollments growing in that same period (52 percent). This has meant less money to be spread among more students. (See Table III).

It should be noted that the limitation on the amount of an individual traineeship award puts the Schools of Public Health at a competitive disadvantage in recruiting physician students in residency programs. In revising P.L. 94-484, ASPH urges Congress to provide the same latitude on the amount of traineeship funds allocated to physicians in clinical residency programs in medical schools. This concern is adequately addressed in Section 794(D).

Traineeship support to students in Schools of Public Health is justified on the grounds that a majority of our students enter (or re-enter) public service. A recent ASPH survey* of 1979 graduates shows that 50 percent worked in tax supported agencies of the Federal, state, regional and local governments and 26 percent worked for voluntary and non-profit, private health organizations. Over 32 percent of the 1979 graduates are providing public service administrative, planning or evaluation services, 15 percent education or other training services in public health, 5 percent public health community organizational services and 38 percent are providing technical services such as clinical, laboratory, social and environmental services.

*Survey and analysis by Thomas Hall, M.D., of the School of Public Health at the University of North Carolina. (See Attachment B).

Again, Schools of Public Health train men and women* primarily for service in the public sector in the areas of health promotion, disease prevention and in the organization and administration of health services.

III. Special Projects

ASPH supports the special projects grant section of H.R. 2004 (Section 793). This section goes further in greatly re-gaining the losses to the Schools brought on by inflation. As inflation has gone up, Federal assistance in special project grants has gone down. In FY 1973, the Congress appropriated \$6 million for special projects; in FY 1981 it approved \$5 million which represents \$3.0 million in 1972 dollars. Yet School enrollment increased 40 percent since 1973. (See Table IV).

These grants are used for projects that are designed to place emphasis on curriculum in the areas of national public health manpower needs (epidemiology, biostatistics, health administration, nutrition, gerontology, environmental and occupational health, maternal and child health, among others). These grants are used to complement Federal initiatives that are stimulating a growing demand for public health personnel.

The special project grants program began in 1960 and was intended to aid accredited Schools of Public Health to develop new programs and expand existing programs in biostatistics and epidemiology, health administration, health planning, health policy analysis and planning, environmental and occupational health and dietetics and nutrition. An amendment by the 95th Congress opened this authority to any educational entity offering programs in the above areas without increasing the authorization level.

Project grants provide support for the development of training opportunities in public health to meet emerging national priorities for public health manpower competencies. These include the training of leadership for management and specialized responsibilities in new and projected health agencies such as HMOs, PSROs, HSAs and agencies to control environmental health hazards, plus private industry.

Project grant appropriations have been decreasing since 1973. Inflationary pressures have accelerated that decline. Calculated in constant dollars in the FY 1980 appropriation of \$5 million is 40 percent less than the amount appropriated in FY 1973. (See Table IV).

Further, Schools of Public Health do not receive all of the money appropriated. As a competitive program, Schools of Public Health must now compete with all programs in health administration, environmental health, nutrition and other educational entities offering training in the specified fields. However, we support Federal assistance to these programs since they greatly contribute to the needed public health manpower pool. H.R. 2004 earmarks these funds for the Schools.

ASPH supports the increased authorization levels in H.R. 2004 for special project grants to Schools of Public Health. Here is the justification. Training and research funds are available in certain fields such as toxicology, nutrition, occupational safety and health to partially support students and to purchase supplies and equipment.

*In 1979-80, 53.6 percent of public health students were women.

However, there are no categorical funds available, except the old formula grants and the present capitation grants that provide support for curriculum development and program support. ASPH believes that increases for special project grants would provide the basic generic support for improving the quality of the curriculum and teaching techniques and enhance the capacity of the Schools and health administration programs to provide health promotion and disease prevention as well as health services management activities in the community, state and Nation.

IV. Preventive Medicine, Dentistry and Public Health Residencies

ASPH supports Section 749(D) that provides support for residencies in public health and preventive medicine. Healthy People underlined the need to increase the supply of professionals in these special practice areas. Also a recent Institute of Medicine report, "A Manpower Policy for Primary Health Care", made a number of recommendations including one to increase the number of residency positions in preventive medicine. The recent GMENAC* report also pointed out the need for physicians in this specialty area (See Attachment C).

ASPH concurs with its sister organizations, the American College of Preventive Medicine and the American Teachers of Preventive Medicine, in their efforts to have Congress recognize the special needs of programs in preventive medicine. They maintain that if a change is to be effected in the health care system to bring about a greater emphasis on prevention, a change must be made in the attitudes and behavior of the medical profession. Medical students, and hence physicians, are not trained to understand the potential of prevention. To promote an awareness of prevention within the medical profession, it is necessary to foster integration of prevention principles within federal policy regarding health manpower training. These organizations (including ASPH) are pleased that H.R. 2004 attempts to accomplish this by providing incentives for medical schools to integrate prevention within their curriculum and by providing direct support for departments of preventive medicine and residency training to students in preventive medicine in Schools of Public Health. However, ASPH urges the Committee to allow those Schools of Public Health that serve as departments of preventive medicine or dentistry for on-campus medical schools the opportunity to participate in programs outlined in Section 794(c).

V. Continuing Education and Health Policy and Management Training

ASPH urges the Committee to enact Section 794 of H.R. 2004 that targets funds for continuing education programs designed to train on-the-job professionals in the latest developments of health policy, management, finance and administration. Recent enactment of Federal health and environmental laws, plus expanding expectations for health, increased public participation in personal and national health affairs, greater demand for competition models and improved health services management, all have created a demand for the upgrading of skills for professionals working in health promotion and disease prevention and health administration fields. According to recent reports, of the approximately 150,000 people from the public health work force, only 25 percent are graduates of Schools of Public Health or other health professional training programs. One-half of the total requires short-term re-training in order to help them keep up with the growing complexities of health programs and the ever increasing base of knowledge and technology. Section 794 should also provide funds to Schools of Public Health to conduct programs in traditional areas of continuing education.

* 1980 Report to HHS by the Graduate Medical Education National Advisory Committee (GMENAC). See Attachment C.

There is an urgent need for trained policy planners and managers throughout the health system, including many in public and private non-profit agencies and institutions that are not directly engaged in the provision of hands-on care for the ill, but do impact on the availability, quality and cost of medical care, and on health services generally, including disease prevention, health promotion, and protection of the public from hazards to health (radiation, toxic substances, air and water pollution, etc.).

ASPH urges the Members to support programs that effect constructive change by widening the perspectives and increasing the management capabilities of senior and mid-level executives and leaders who are responsible for directing health agencies such as HMOs, HSAs, community health centers, hospitals, state and local health departments, environmental agencies, among others, including industry managers.

VI. Facilities Maintenance

ASPH urges the Committee to approve provisions in the health manpower act that provide assistance to Schools of Public Health for construction, renovation and/or refurbishment of facilities to provide appropriate teaching and research environments for students and faculty. H.R. 2004 would support the Schools in expanding their programs in vital public health disciplines to incorporate the necessary elements which ASPH maintains are so desperately needed. However, the bill does not provide funds for additional space requirements that would be needed if H.R. 2004 is enacted.

Present plans to terminate grants for construction and extremely limited funds for renovation of teaching facilities, ignore the implications of federal laws, initiatives and the Surgeon General's report which will stimulate the growing demand for public health manpower. If assumptions regarding growing demands are true, the Schools of Public Health will need the construction grants in order to expand their facilities to accommodate the necessary increase in enrollments. Many of the 21 Schools of Public Health are operating at their capacity level. Expansion of enrollment to meet the growing demand will mean overcrowded and inappropriate teaching conditions.

VII. Health Personnel Data and Manpower Projections

ASPH requests extension of Section 793 of P.L. 94-484 that asks the Secretary to collect, compile and analyze data on all sectors involved in the health services delivery system. With the demands being placed on the Schools of Public Health to provide data to the executive and legislative branches of the Federal government, it becomes imperative that a centralized system of data collection be continued. At the present time such a system is operating and can provide information on applicants, students, graduates, faculty research projects and expenditures in Schools of Public Health. Because of the need for authentic data produced in a timely fashion, Federal funding is necessary to maintain surveillance on public health manpower production in the Schools of Public Health. Also, this type of data collection and surveillance needs to be extended to other schools and programs that produce specialized health manpower personnel.

Further in an effort to monitor the ability of the production system to fill manpower requirements of the work force, studies must be undertaken to assess public health manpower requirements in all sector of the health delivery system, especially in the public sector. Contrary to the other health professions (physicians, nurses, dentists, pharmacists, veterinarians, optometrists, etc.) no federal studies have been undertaken on the need for the present or future supply of public health workers. We strongly support Section 231(a) that calls for a study in the environmental health field.

ASPH urges the Committee to provide assistance to not only conduct studies to determine the demand for public health personnel, but to determine the cost of educating and training community and public health workers, as well as identifying functional and geographic areas in which there are shortages in national priority needs.

VIII. The Administration's Proposal

We understand that the Administration's bill will propose to end capitation but it will continue to provide limited support and curriculum development monies to Schools of Public Health. Recent HHS reports to Congress state that a short supply of public health personnel exists in our Nation. It is surprising and confusing, therefore, for the Administration to propose drastic reductions in Federal support to Schools of Public Health. Given the present state of the economy, certain reductions in Federal spending is justified. However, to recommend cuts in programs that contribute to keeping individuals out of the medical care system does not make sense. Cost savings in the health care system can be achieved through greater emphasis (not reductions) on programs that keep people and communities healthy.

IX. Summary

ASPH urges the Committee to include references to public health in the preamble of the bill that would amend P.L. 94-484. ASPH suggests that the revised act be complementary to the Surgeon General's report Healthy People:

It is the thesis of this report that further improvements in the health of the American people can and will be achieved -- not alone through increased medical care and greater health expenditures -- but through a renewed national commitment to efforts designed to prevent disease and to promote health.

Further, the preamble should note another finding in Healthy People:

In the field of public health, in contrast to personal health, manpower shortages are believed to exist in some key fields, including occupational health, epidemiology, biostatistics, and health services administration.

In summary, the ASPH believes that continued Federal assistance is actually an investment at the front end of the health care system. The Schools (i.e., through their students, graduates, researchers, faculty and community service programs) will not only help prevent illness but will also help slow down the rapidly escalating costs of medical care. Providing basic institutional and student support is a means whereby the Federal government can share the costs with state and private institutions for the training of public health personnel to manage and operate governmental health programs. Public health is a public responsibility. Schools of Public Health train personnel for public service. The Federal government has a direct interest in assuring that an adequate supply of public health personnel is trained in quality institutions to manage and operate the health delivery system in the national interest.

ASPH thanks the Members of the House Energy and Commerce Subcommittee on Health and the Environment for the opportunity to present its views on H.R. 2004, the "Health Professions and Educational Assistance and Nurse Training Amendments of 1981". ASPH urges favorable consideration of H.R. 2004 with suggestions outlined in this statement.

TABLE I
Budget History
Public Health Training Appropriations
(Constant Dollars)¹
1964 - 1980

Year	No. Schools	GNP Deflator	Total ²	Project ²	Formula ² (Institutional Traineeships ² Support)	
1964	14	63.3	\$12,788,300	\$3,159,550	\$3,001,570	\$6,627,170
1965	14	65.1	14,592,900	3,840,240	3,840,240	6,912,440
1966	15	68.4	21,198,800	5,847,950	5,116,950	10,233,910
1967	15	72.5	23,103,400	6,896,550	5,172,410	11,034,480
1968	15	76.9	21,456,400	5,851,750	5,201,560	10,403,120
1969	16	81.9	21,332,100	6,003,660	5,560,430	9,768,000
1970	16	88.3	20,465,400	5,568,516	5,836,910	9,060,020
1971	17	94.5	19,016,900	4,779,890	5,348,140	8,888,880
1972	17	100.0	18,471,000	4,517,000	5,554,000	8,400,000
1973	18	107.5	20,093,000	5,581,390	5,581,390	8,930,230
1974	18	118.9	17,258,200	4,793,940	4,793,940	7,670,310
1975	19	127.3	16,119,400	4,320,500	4,634,720	7,164,180
1976	19	137.7	14,901,900	3,994,190	4,284,670	6,623,090
1977	19	146.2 ³	14,035,500	3,761,970	4,035,560	6,238,030
1978	21	150.3 ⁴	11,909,500	3,326,680	3,925,480	4,657,350
1979	21	162.7	10,947,113	3,071,819	3,624,747	4,300,547
1980	21	177.3	10,431,350	2,819,284	3,665,069	3,946,997

¹ Implicit price deflator for GNP, 1972 = 100. Economic Report of the President, January 1976

² Rounded

³ Second Quarter 1977

⁴ Estimated

TABLE II
 Appropriations History
 Public Health Institutional Support
 Current and Constant Dollars
 1964 - 1980

Fiscal Year	No. Schools	Appropriation	(State/local gov't) GNP Deflator ¹	Appropriation (in constant dollars) ²
1964	14	\$1,900,000	63.3	\$3,001,570
1965	14	2,500,000	65.1	3,840,240
1966	15	3,500,000	68.4	5,116,950
1967	15	3,750,000	72.5	5,172,410
1968	15	4,000,000	76.9	5,201,560
1969	16	4,554,000	81.9	5,560,430
1970	16	5,154,000	88.3	5,836,910
1971	17	5,054,000	94.5	5,348,140
1972	17	5,554,000	100.0	5,554,000
1973	18	6,000,000	107.5	5,581,390
1974	18	5,700,000	118.9	4,793,940
1975	19	5,900,000	127.3	4,634,720
1976	19	5,900,000	137.7	4,284,670
1977	19	5,900,000	146.2 ³	4,035,560
1978 ⁵	21	5,900,000	150.3 ⁴	3,925,480
1979	21	5,900,000	162.7	3,624,747
1980	21	6,500,000	177.3	3,665,069

¹ Implicit price deflator for GNP, 1972 = 100. Economic Report of the President, January 1976

² Rounded

³ Second quarter 1977

⁴ Estimated

⁵ First year for Capitation grant allocation

TABLE III
Budget History
Public Health Traineeship Appropriations
(In Current and Constant Dollars¹)
1964 - 1980

Year	No. Schools	(Current \$) Traineeships	GNP Deflator	(Constant \$) ² Traineeships
1964	14	\$4,195,000	63.3	\$6,627,170
1965	14	4,500,000	65.1	6,912,440
1966	15	7,000,000	68.4	10,233,910
1967	15	8,000,000	72.5	11,034,480
1968	15	8,000,000	76.9	10,403,120
1969	16	8,000,000	81.9	9,768,000
1970	16	8,000,000	88.3	9,060,020
1971	17	8,400,000	94.5	8,888,880
1972	17	8,400,000	100.0	8,400,000
1973	18	9,600,000	107.5	8,930,230
1974	18	9,120,000	118.5	7,670,310
1975	19	9,120,000	127.3	7,164,180
1976	19	9,120,000	137.7	6,623,090
1977	19	9,120,000	146.2 ³	6,238,030
1978	21	7,000,000	150.3 ⁴	4,657,350
1979	21	7,000,000	162.7	4,300,547
1980	21	7,000,000	177.3	3,946,997

¹ Implicit price deflator for GNP, 1972 = 100. Economic Report of the President, January 1976

² Rounded

³ Second quarter 1977

⁴ Estimated

TABLE IV
Budget History
Special Projects in Public Health
(Current and Constant Dollars¹)
1964 - 1980

Year	(Current \$) Project	GNP Deflator	(Constant ² \$) Project ²
1964	\$2,000,000	63.3	\$3,159,550
1965	2,500,000	65.1	3,840,240
1966	4,000,000	68.4	5,847,950
1967	5,000,000	72.5	6,896,550
1968	4,500,000	76.9	5,851,750
1969	4,917,000	81.9	6,003,660
1970	4,917,000	88.3	5,568,516
1971	4,517,000	94.5	4,779,890
1972	4,517,000	100.0	4,517,000
1973	6,000,000	107.5	5,581,390
1974	5,700,000	118.9	4,793,940
1975	5,500,000	127.3	4,320,500
1976	5,500,000	137.7	3,994,190
1977	5,500,000	146.2 ³	3,761,970
1978 ⁵	5,000,000	150.3 ⁴	3,326,680
1979 ⁵	5,000,000	162.7	3,071,819
1980 ⁵	5,000,000	177.3	3,065,069

¹ Implicit price deflator for GNP, 1972 = 100. Economic Report of the President, January 1976

² Rounded

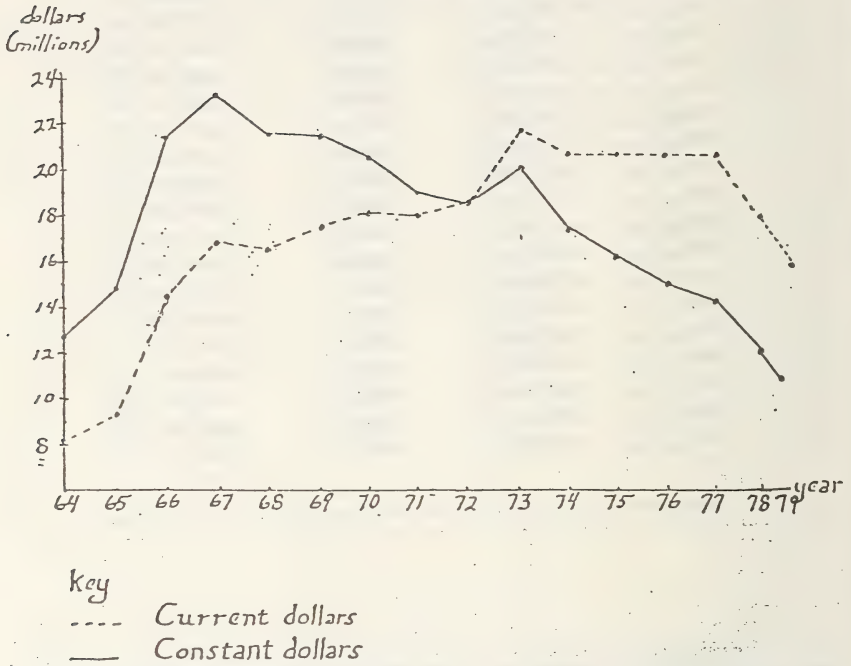
³ Second quarter 1977

⁴ Estimated

⁵ Number of Schools of Public Health: 21

Attachment A

Appropriations History
Current and Constant Dollars
1964-1979



Attachment B
GRADUATES OF SCHOOLS OF PUBLIC HEALTH

Some Highlights of the Preliminary Data on 1978 and 1979 Graduates

1979 1978

Employment

78.4%	82.3%	of the graduates are employed
12.0	12.8	of the graduates have continued their education
9.0	4.2	of the graduates are unemployed

Type of Employing Organization

50.4%	52.0%	of employed graduates work for tax supported organizations such as Federal, State, Regional or Local Government
26.0	22.2	of employed graduates work for Voluntary Health Agencies
12.5	12.2	of employed graduates work for Proprietary Organizations

Types of Services Which Graduates are Providing

32.1%	38.1%	of graduates are providing Administrative, Planning or Evaluation Services
15.4	14.0	of graduates are providing Education and Training to others in Public Health
9.1	9.1	of graduates are providing Consultation Services
5.1	3.3	of graduates are providing Public Health Community Organizational Services
38.3	35.5	of graduates are providing Technical Services such as Clinical, Laboratory, Social and Environmental Services

Earning Levels of Employed Graduates

56.8%	48.0%	or almost one-half of employed graduates earn less than \$19,000 per year
16.6	20.0	of employed graduates earn between \$19,000 to \$22,000
6.2	11.0	of employed graduates earn between \$22,000 to \$25,000
20.4	21.0	of employed graduates earn more than \$25,000

Earning Level of Graduates Prior to Public Health Training

77.4%	83.0%	of graduates earned less than \$19,000
6.0	6.8	of graduates prior to entering SPH earned between \$19,000 and \$22,000
4.4	3.0	of graduates prior to entering SPH earned between \$22,000 and \$25,000
12.2	7.2	of graduates prior to entering SPH earned more than \$25,000

Financial Assistance During Training

77.2%	76.0%	of the graduates had some financial assistance during their education
29.5	33.0	of the graduates had more than 2/3 of their education paid by traineeship, grants or employers

Job Availability for Graduates with Public Health Degrees and Experience

53.9%	62.7%	of graduates with work experience found jobs readily available
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~~Those graduates without prior experience found it more difficult to obtain satisfactory jobs.~~

Attachment C

1990 REQUIREMENTS FOR PUBLIC HEALTH AND
PREVENTIVE MEDICINE

Manpower estimated by GMENAC

On September 23, 1980, the HHS Graduate Medical Education National Advisory Committee (GMENAC) met in Washington and adopted final recommendations (shown below) regarding the needed number of public health physicians for each specialty for 1990.

<u>Present Supply</u>	<u>Aerospace Medicine</u>	<u>Occupational Medicine</u>	<u>Public Health and General Preventive Medicine</u>	<u>Total</u>
Board-certified(1)	783	794	2,317	3,924
Self-identified(2)				
Administration	165	541	1,555	2,291
Research	27	23	201	255
Teaching	7	9	115	131
Patient Care	368	(1,695)*	(1,048)*	368
Other	17	78	147	242
	<u>584</u>	<u>656</u>	<u>2,043</u>	<u>3,283</u>

1990 Requirements for Board-Qualified Full Time Equivalents (3)

Program Activities	250	1,400	2,100	3,750
Research	150	200	400	750
Teaching	60	300	450	810
Clinical Services	500	400**	400**	1,300
Other	0	0	200	200
	<u>960</u>	<u>2,300</u>	<u>3,550</u>	<u>6,810</u>

The estimate of total requirements as calculated above is 6,800-7,800.

Shortage

Number	376	1,644	1,502	3,522
Percent	64	231	73	107

*These are felt to be physicians providing regular clinical services though in a preventive medicine setting. The 2700 physicians have not been included in the final figures because in the GMENAC methodology these physicians have been included in the enumeration of generalist physicians.

**These are in addition to other physician specialists working in a preventive medicine setting but who are providing regular clinical services.

Mr. WAXMAN. Thank you very much. Certainly the statement will be made a part of the record.

Dr. Sundre.

STATEMENT OF STEVEN M. SUNDRE, PH. D.

Dr. SUNDRE. Thank you, Mr. Chairman and members of the committee.

I am Steve Sundre, vice president of the Association of University Programs in Health Administration.

Mr. Chairman, not all of H.R. 2004 disagrees with the known interests of the administration and its expected support in the other body of Congress. Public health and health administration are recognized national priorities on all sides. There is little doubt about either the need or the Federal responsibility.

Improved management is clearly central to the efforts to reduce fraud, abuse and mismanagement of public funds at the local level. Similarly, increased competition requires competence in the management of HMO's, in the management of home health agencies and other organizations which emphasize prevention, primary care and low-cost alternatives.

Section 794 correctly identifies the interventions which are necessary to relieve this management capacity barrier; 794A continues and improves capacity development grounds requiring non-Federal matching support. H.R. 2004 raises the required non-Federal portion by a third which we support. It requires programs to offer concentrations in fields of particular shortage which we also believe to be appropriate.

This and other sections applied to Health Administration comprise a balanced, a logical and a low-cost approach to the need. We have a number of recommendations for change, most of them minor, which are included with this testimony and are submitted for the record.

Most essentially we urge discontinuation of the requirement for constant enrollment expansion. That process has served its purpose well but if continued will make vitally important and vitally needed continuing education very difficult to offer.

The midcareer training provision is overly restrictive to one format. We recommend a more flexible authority which will encourage more competition and expanded impact for the same investment.

Finally, Mr. Chairman, and you may find this a shock, but we believe that all of the objectives of the management components can be accomplished for \$12 million less than the authorized total in H.R. 2004. Our business is management and the business of management is better use of resources. We are ready to do our share to cut costs and believe it can be accomplished by implementing the changes suggested in our proposed amendments.

The point is that with less funds greater flexibility will contribute to the objective of increasing opportunity for health management education. The general structure of the health administration provision is logical and appropriate and should be retained.

Thank you.

Mr. WAXMAN. Thank you very much.

[Testimony resumes on p. 329.]

[Dr. Sundre's prepared statement follows:]

STATEMENT OF STEVEN M. SUNDRE, PH.D.
ASSOCIATION OF TEACHERS OF PREVENTIVE MEDICINE

Mr. Chairman, members of the Committee:

I am Steve Sundre, Vice President of the Association of University Programs in Health Administration.

Mr. Chairman, not all of H.R. 2004 disagrees with the known interest of the Administration and its expected support in the other body of Congress. Public health and health administration are recognized national priorities on all sides. There is little doubt about either the need or the Federal responsibility. Improved management is clearly central to efforts to reduce fraud, abuse, and mismanagement of public funds at the local level. Similarly, increased competition requires competence in the management of HMO's, home health agencies, and other organizations which emphasize prevention, primary care, and low cost alternatives.

Section 794 correctly identifies the interventions which are necessary to relieve the management capacity barrier. 794A continues and improves capacity development grants requiring non-Federal matching support. H.R. 2004 raises the required non-federal portion by a third, which we support. It requires programs to offer concentrations in fields of particular shortage, which we also believe to be appropriate.

This and the other sections applied to Health Administration comprise a balanced, logical, and low cost approach to the need. We have a number of recommendations for change, most of them minor, which are included with this testimony and are submitted for the record.

Most essentially, we urge discontinuation of the requirement for constant enrollment expansion. That process has served its purpose well, but, if continued, will make vitally needed continuing education very difficult to offer.

The midcareer training provision is overly restrictive to one format. We recommend a more flexible authority which will encourage more competition and expanded impact for the same investment.

Finally, Mr. Chairman, you may find this a shock, but we believe that all of the objectives of the management components can be accomplished for \$12 million less than the authorized total in H.R. 2004. Our business is management; the business of management is better use of resources. We are ready to do our share to cut costs and believe it can be accomplished by implementing the changes suggested in the attached amendments.

The point is that with less funds, greater flexibility will contribute to the objective of increasing opportunity for health management education. The general structure of the health administration provision is logical and appropriate and should be retained.

Thank you.

RECOMMENDED LANGUAGE OF SECTIONS RELATED TO HEALTH SERVICES
ADMINISTRATION

EXISTING SECTION 791 (a)
H.R. 2004 Sec. 794A

FROM FUNDS APPROPRIATED UNDER SUBSECTION (d),
THE SECRETARY SHALL MAKE ANNUAL GRANTS TO PUBLIC OR
NONPROFIT PRIVATE EDUCATIONAL ENTITIES (EXCLUDING
ACCREDITED SCHOOLS OF PUBLIC HEALTH) TO SUPPORT THE
GRADUATE EDUCATIONAL PROGRAMS OF SUCH ENTITIES IN
HEALTH SERVICES ADMINISTRATION.

- (b) THE AMOUNT OF THE GRANT FOR ANY FISCAL YEAR UNDER
SUBSECTION (a) TO AN EDUCATIONAL ENTITY WITH AN
APPLICATION APPROVED UNDER SUBSECTION (c) SHALL BE
EQUAL TO THE AMOUNT APPROPRIATED UNDER SUBSECTION (d)
FOR SUCH FISCAL YEAR DIVIDED BY THE NUMBER OF
EDUCATIONAL ENTITIES WHICH HAVE APPLICATIONS FOR
GRANTS FOR SUCH FISCAL YEAR APPROVED UNDER
SUBSECTION (c).
- (c) (1) NO GRANT MAY BE MADE UNDER SUBSECTION (a) UNLESS
AN APPLICATION THEREFORE HAS BEEN SUBMITTED TO
THE SECRETARY BEFORE SUCH TIME AS HE SHALL BY
REGULATION PRESCRIBE AND HAS BEEN APPROVED BY THE
SECRETARY. SUCH APPLICATION SHALL BE IN SUCH FORM,
AND SUBMITTED IN SUCH MANNER, AS THE SECRETARY
SHALL BY REGULATION, PRESCRIBE.
- (2) THE SECRETARY MAY NOT APPROVE AN APPLICATION
SUBMITTED UNDER PARAGRAPH (1) UNLESS -
 - (A) SUCH APPLICATION -
 - (i) CONTAINS ASSURANCES SATISFACTORY TO
THE SECRETARY THAT IN THE SCHOOL YEAR
(AS DEFINED IN REGULATIONS OF THE
SECRETARY) BEGINNING IN THE FISCAL YEAR
FOR WHICH THE APPLICANT RECEIVES A

GRANT UNDER SUBSECTION (a) THAT -

- (I) AT LEAST 25 INDIVIDUALS WILL COMPLETE THE GRADUATE EDUCATIONAL PROGRAM FOR WHICH SUCH APPLICATION IS SUBMITTED: AND
- (II) SUCH ENTITY SHALL EXPEND OR OBLIGATE AT LEAST \$150,000 IN FUNDS FROM NON-FEDERAL SOURCES TO CONDUCT SUCH PROGRAMS:
- (ii) THE PROGRAM FOR WHICH SUCH APPLICATION WAS SUBMITTED SHALL PROVIDE, OR PLANS TO PROVIDE WITHIN 12 MONTHS A CONCENTRATION OR SPECIAL EMPHASIS ON ONE OR MORE OF THE FOLLOWING:
 - (I) HEALTH PLANNING AND POLICY
 - (II) AMBULATORY CARE SERVICES
 - (III) PRIMARY CARE SERVICES
 - (IV) LONG TERM CARE
 - (V) HOME HEALTH SERVICES
 - (VI) MULTI-UNIT SYSTEMS
 - (VII) HMO's AND PREPAID SERVICES SYSTEMS
 - (VIII) MENTAL HEALTH SERVICES, AND
 - (IX) ANY OTHER HEALTH SERVICE SYSTEM DETERMINED BY THE SECRETARY TO REQUIRE SPECIAL EMPHASIS: AND
- (iii) CONTAINS SUCH OTHER INFORMATION AS THE SECRETARY MAY BY REGULATION PRESCRIBE: AND
- (B) THE PROGRAM FOR WHICH SUCH APPLICATION WAS SUBMITTED HAS BEEN ACCREDITED FOR THE TRAINING OF INDIVIDUALS FOR HEALTH SERVICES ADMINISTRATION BY A RECOGNIZED BODY APPROVED FOR SUCH PURPOSE BY THE SECRETARY OF EDUCATION AND MEETS SUCH OTHER QUALITY STANDARDS AS THE SECRETARY SHALL BY REGULATION PRESCRIBE.
- (3) THE SECRETARY MAY NOT APPROVE OR DISAPPROVE AN APPLICATION SUBMITTED UNDER PARAGRAPH (1) EXCEPT AFTER CONSULTATION WITH THE NATIONAL ADVISORY

COUNCIL ON HEALTH PROFESSIONS EDUCATION.

- (d) THERE ARE AUTHORIZED TO BE APPROPRIATED FOR PAYMENTS UNDER GRANTS UNDER THIS SECTION \$4,000,000 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1982, \$5,000,000 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1983, AND \$5,250,000 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1984.

HEALTH SERVICES ADMINISTRATION STUDENT TRAINEESHIPS

EXISTING SECTION 749 (a)
H.R. 2004 Sec. 794B

THE SECRETARY SHALL MAKE GRANTS TO PUBLIC OR NON PROFIT EDUCATIONAL ENTITIES (EXCLUDING ACCREDITED SCHOOLS OF PUBLIC HEALTH) WHICH OFFER A PROGRAM IN HEALTH SERVICES ADMINISTRATION WHICH IS ACCREDITED BY A BODY APPROVED FOR SUCH PURPOSE BY THE SECRETARY OF EDUCATION AND WHICH MEETS SUCH OTHER QUALITY STANDARDS AS THE SECRETARY BY REGULATION MAY PRESCRIBE, FOR STUDENTS WHO ARE CITIZENS OF THE UNITED STATES, OR LAWFULLY ADMITTED TO THE UNITED STATES FOR PERMANENT RESIDENCE AS DEFINED IN SECTION 101 (a) (20) OF THE IMMIGRATION AND NATIONALITY ACT, OR CITIZENS OF THE NORTHERN MARIANA ISLANDS, AMERICAN SAMOA, OR THE TRUST TERRITORY OF THE PACIFIC ISLANDS ENROLLED IN SUCH A PROGRAM.

- (b) (1) NO GRANT FOR TRAINEESHIPS MAY BE MADE UNDER SUBSECTION (a) UNLESS AN APPLICATION THEREFOR HAS BEEN SUBMITTED TO, AND APPROVED BY, THE SECRETARY. SUCH APPLICATION SHALL BE IN SUCH FORM, BE SUBMITTED IN SUCH MANNER, AND CONTAIN SUCH INFORMATION, AS THE SECRETARY BY REGULATION MAY PRESCRIBE. TRAINEESHIPS UNDER SUCH A GRANT SHALL BE AWARDED IN ACCORDANCE WITH SUCH REGULATIONS AS THE SECRETARY SHALL PRESCRIBE. THE AMOUNT OF ANY SUCH GRANT SHALL BE DETERMINED BY THE SECRETARY.
- (2) TRAINEESHIPS AWARDED UNDER GRANTS MADE UNDER

SUBSECTION (a) SHALL PROVIDE FOR TUITION AND FEES AND SUCH STIPENDS AND ALLOWANCES (INCLUDING TRAVEL AND SUBSISTENCE EXPENSES AND DEPENDENCY ALLOWANCES) FOR THE TRAINEES AS THE SECRETARY MAY DEEM NECESSARY.

- (3) IN AWARDING TRAINEESHIPS UNDER THIS SECTION, EACH APPLICANT SHALL PROVIDE ASSURANCES TO THE SECRETARY THAT THE FUNDS RECEIVED UNDER THIS SECTION SHALL BE AWARDED FOR TRAINEESHIPS TO INDIVIDUALS WHO HAVE RECEIVED A BACCALAUREATE DEGREE.

- (c) FOR PAYMENTS UNDER GRANTS UNDER SUBSECTION (a), THERE ARE AUTHORIZED TO BE APPROPRIATED \$2,500,000 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1982, \$2,500,000 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1983, AND \$2,500,000 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1984.

NATIONAL PRIORITY CURRICULUM IMPROVEMENT PROJECTS FOR GRADUATE PROGRAMS IN HEALTH SERVICES ADMINISTRATION

- H.R. 2004 Sec. 794E (a) THE SECRETARY SHALL MAKE GRANTS TO ASSIST EDUCATIONAL INSTITUTIONS WITH ACCREDITED GRADUATE PROGRAMS IN HEALTH SERVICES ADMINISTRATION TO MEET THE COSTS OF DEVELOPING NEW, IMPROVED AND EXPANDED CURRICULA TO IMPROVE SHORT-TERM AND LONG-TERM HEALTH MANAGEMENT TRAINING. SUCH CURRICULA MAY INCLUDE -
- (1) HEALTH SERVICES FINANCE;
 - (2) HEALTH SERVICES MARKETING;
 - (3) HEALTH SERVICES ACCOUNTING;
 - (4) HEALTH ECONOMICS;
 - (5) EPIDEMIOLOGY AND HEALTH PLANNING;
 - (6) HEALTH POLICY, LAW AND REGULATION;
 - (7) QUALITY ASSURANCE AND ASSESSMENT;
 - (8) HEALTH INFORMATION SYSTEMS;
 - (9) MANAGEMENT OF PRIMARY AND AMBULATORY CARE; AND
 - (10) HEALTH SERVICES ORGANIZATION AND MANAGEMENT FOR STUDENTS IN OTHER HEALTH DISCIPLINES.

- (b) FOR PURPOSES OF SUBSECTION (a), THE TERM "ACCREDITED PROGRAM IN HEALTH SERVICES ADMINISTRATION" MEANS A GRADUATE PROGRAM WHICH IS ACCREDITED FOR THE PURPOSE OF TRAINING INDIVIDUALS IN HEALTH ADMINISTRATION BY A BODY APPROVED FOR SUCH PURPOSE BY THE SECRETARY OF EDUCATION.
- (c) FOR PURPOSE OF MAKING GRANTS UNDER SUBSECTION (a) THERE ARE AUTHORIZED TO BE APPROPRIATED \$2,500,000 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1982, \$3,500,000 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1983, AND \$4,250,000 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1984.

CRITICAL SHORTAGE FACULTY DEVELOPMENT PROJECTS

- H.R. 2004 Sec. 794F (a) THE SECRETARY SHALL MAKE GRANTS TO ASSIST EDUCATIONAL INSTITUTIONS WITH ACCREDITED GRADUATE PROGRAMS IN HEALTH SERVICES ADMINISTRATION TO MEET THE COSTS OF ESTABLISHING AND OPERATING PROGRAMS TO DEVELOP HEALTH ADMINISTRATION FACULTY IN FIELDS OF NATIONAL SHORTAGE. SUCH FACULTY DEVELOPMENT PROGRAMS SHALL TRAIN INDIVIDUALS IN HEALTH AND MANAGEMENT DISCIPLINES THAT ARE, IN THE JUDGMENT OF THE SECRETARY, UNDER-REPRESENTED IN PROGRAMS IN HEALTH SERVICES ADMINISTRATION AND WHICH ARE NECESSARY TO MEET NATIONAL HEALTH ADMINISTRATION TRAINING REQUIREMENTS.
- (b) NO GRANT MAY BE MADE UNDER SUBSECTION (a) UNLESS AN APPLICATION THEREFOR IS SUBMITTED TO AND APPROVED BY THE SECRETARY. SUCH AN APPLICATION SHALL BE IN SUCH FORM, BE SUBMITTED IN SUCH MANNER, AND CONTAIN SUCH INFORMATION AS THE SECRETARY SHALL PRESCRIBE. THE SECRETARY MAY NOT APPROVE AN APPLICATION FOR A GRANT UNDER SUBSECTION (a) UNLESS SUCH APPLICATION CONTAINS ASSURANCES SATISFACTORY TO THE SECRETARY THAT AT LEAST THREE INDIVIDUALS SHALL COMPLETE THE PROGRAM IN EACH YEAR FOR WHICH APPLICATION IS MADE.

- (c) GRANT FUNDS AWARDED UNDER SUBSECTION (a) SHALL BE USED TO PROVIDE 12 MONTH FELLOWSHIPS TO INDIVIDUALS WHO -
 - (1) HAVE RECEIVED A DOCTORAL DEGREE OR EQUIVALENT PROFESSIONAL RECOGNITION IN A DISCIPLINE DETERMINED BY THE SECRETARY TO BE UNDERREPRESENTED IN PROGRAMS IN HEALTH SERVICES ADMINISTRATION AND NECESSARY TO IMPROVE TRAINING IN HEALTH CARE MANAGEMENT; AND
 - (2) AGREE TO SERVE AS A FACULTY MEMBER FOR A PERIOD OF NOT LESS THAN TWO YEARS IN A PROGRAM IN HEALTH SERVICES ADMINISTRATION.
- (d) FOR PURPOSES OF SUBSECTION (a), THE TERM "ACCREDITED PROGRAM IN HEALTH SERVICES ADMINISTRATION" MEANS A GRADUATE PROGRAM WHICH IS ACCREDITED FOR THE PURPOSE OF TRAINING INDIVIDUALS IN HEALTH ADMINISTRATION BY A BODY APPROVED BY THE SECRETARY OF EDUCATION.
- (e) FOR THE PURPOSE OF MAKING GRANTS UNDER SUBSECTION (a), THERE ARE AUTHORIZED TO BE APPROPRIATED \$1,500,000 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1982, \$2,000,000 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1983, AND \$2,500,000 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1984.

MANAGEMENT TRAINING FOR HEALTH CARE PROFESSIONALS

- H.R. 2004 Sec. 794(a) (a) THE SECRETARY SHALL MAKE GRANTS AND ENTER INTO CONTRACTS WITH PUBLIC AND NONPROFIT PRIVATE EDUCATION INSTITUTIONS AND OTHER NONPROFIT PRIVATE ENTITIES FOR THE ESTABLISHMENT AND OPERATION OF NON DEGREE MANAGEMENT TRAINING PROGRAMS FOR PHYSICIANS, NURSES, OTHER PROVIDERS OF HEALTH CARE, ADMINISTRATORS IN HEALTH CARE FACILITIES, STATE AND LOCAL HEALTH AGENCIES AND HEALTH PLANNING AGENCIES, IN -
- (1) HEALTH SYSTEMS MANAGEMENT,

- (2) HEALTH POLICY, PLANNING, AND REGULATION;
 - (3) HEALTH FINANCIAL MANAGEMENT,
 - (4) MANAGEMENT OF INTERAGENCY AND INTERFACILITY COLLABORATION,
 - (5) THE MANAGEMENT OF SMALL RURAL AND INNER CITY HEALTH SERVICES.
- (b) (1) THE AMOUNT OF ANY GRANT OR CONTRACT UNDER SUBSECTION (a) SHALL BE DETERMINED BY THE SECRETARY. NO GRANT MAY BE MADE OR CONTRACT ENTERED INTO UNLESS AN APPLICATION THEREFOR IS SUBMITTED TO AND APPROVED BY THE SECRETARY. SUCH AN APPLICATION SHALL BE IN SUCH FORM, SUBMITTED IN SUCH MANNER, AND CONTAIN SUCH INFORMATION, AS THE SECRETARY SHALL BY REGULATION PRESCRIBE.
- (2) THE SECRETARY SHALL, TO THE EXTENT FEASIBLE, MAKE GRANTS AND ENTER INTO CONTRACTS UNDER SUBSECTION (a) FOR TRAINING PROGRAMS IN SUCH A MANNER THAT THERE IS AN APPROPRIATE GEOGRAPHIC DISTRIBUTION OF THE TRAINING PROGRAMS.
- (c) FOR THE PURPOSE OF MAKING GRANTS AND CONTRACTS UNDER SUBSECTION (a), THERE ARE AUTHORIZED TO BE APPROPRIATED \$1,000,000 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1982, \$1,500,000 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1983, AND \$2,000,000 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1984.

Mr. WAXMAN. Mr. Rabin.

STATEMENT OF DAVID RABIN, M.D.

Dr. RABIN. Mr. Chairman and subcommittee members, I am Dr. David Rabin from the Georgetown University School of Medicine and I am past president of the Association of Teachers of Preventive Medicine, an organization that represents teachers in the schools of medicine in the United States.

I am commenting today on manpower legislation 2004 and my remarks are supported as well by the American College of Preventive Medicine who are the practitioners of preventive medicine.

Our departments in medical schools are responsible for teaching students, usually medical students but often graduate students at a master's level, in areas of health education, biostatistics, epidemiology, nutrition, ethics, and health care organization.

In my remarks this morning I am going to emphasize health care organization because I feel that is central to your concern and responsibility at this point and I think we have a major contribution to make within that area.

A major concern for you at this point is containment of Federal health expenditures. The rapidly escalating costs of medical care require examination of various means of cost containment. In a year of declining Federal expenditures investment in prevention is vital as a means of cost containment.

Control of health care costs while maintaining acceptable health levels can only be done by more effective prevention services. These services must be provided both through the community and by better integration of preventive with curative care when the doctor sees the patient.

Currently, health care is the science of diagnosis and treatment. This science increasingly depends on costly technology and therapy. As biomedical science advances so will the cost of health care if we rely primarily on technology to prevent disease. We must practice prevention as a means of reducing disease, thus curtailing costs.

If a change is to be effected in our health care system we must affect the knowledge and attitudes of the individuals who run that system, health professionals in particular physicians. Unfortunately, many of today's average practicing physician was not equipped as a part of his or her medical education with attitudes and skills necessary to prevent disease.

Patients today frequently report, and you may have had this experience yourselves, that they are more knowledgeable in preventive nutrition and exercise than their own physicians. Yet there does exist a body of knowledge which if properly taught could provide physicians prevention skills and affect the health of their patients. However, the hope which prevention holds is in stark contrast to current medical school realities.

Of the Nation's medical schools only 70 percent have departments of preventive medicine. Of these some are faced with impending closure. Federal support for projects in preventive medicine within medical schools have dropped precipitously from \$1.1 million in 1979 to zero in 1980. On an average less than 1½ percent

of the total undergraduate medical curriculum is devoted to prevention.

Physicians are not going to be recruited into specializing and spending their careers in prevention in the absence of any exposure to formal prevention within their medical education.

Although it has been estimated that 6,800 preventive medicine specialists will be needed in the year 1990, current residency training programs will only train 3,300, a shortfall of 125 percent. At the same time Federal support for residency training has dropped from \$1.2 million in 1973 to \$275,000 in 1980.

Preventive medicine residents, unlike all other post-graduate training physicians, do not earn money for the institutions at which they are being trained. These institutions in turn are not going to teach residents whom they can't support.

The career of physicians going into preventive medicine is analogous to those of other public health workers. They serve the public and they serve the public at salaries and incomes substantially less than their private practice or clinically practicing colleagues. Failure to support graduate and residency training in preventive medicine will be detrimental to the patients seen by physicians and thus ultimately costly to the public.

We are therefore pleased to support H. R. 2004. The minimal investment it requests for preventive curriculum and manpower development can make a difference in the attitudes and skills of our future physicians.

We therefore urge inclusion of the existing prevention provisions in sections 794(c) and (d) in the final committee bill.

In addition we lend our wholehearted support to those provisions of H. R. 2004 which relate to public health and health administration, subjects which my colleagues here previously testified on.

We would like as well to place a more formal and expanded statement in the minutes of the meeting and would be delighted to answer any questions.

[Testimony resumes on p. 345.]

[Dr. Rabin's prepared statement follows:]

Statement of the
Association of Teachers of Preventive Medicine

The Association of Teachers of Preventive Medicine is pleased to submit the following comments on HR 2004, The Health Professions Educational Assistance and Nurse Training Amendments of 1981. The remarks which follow are also endorsed by the American College of Preventive Medicine, the professional society for preventive medicine physicians and a sister organization.

The Association of Teachers of Preventive Medicine is a small academic society composed of some 600 individual members who are largely medical faculty and some 60 medical school departments of preventive medicine. The Association has as its overriding goal the advancement of prevention as a component of health professions education.

It is widely recognized that we are rapidly approaching what could be termed a crisis situation in the health care field. Although, as stated recently by the Surgeon General, the health of the American people has never been better, our nation's annual health care bill has skyrocketed to a level unthought of just years ago. This condition cannot go unchecked -- with that all can agree. However, questions and disagreements as to how we, as a nation, are to address this problem will continue to abound as we attempt to grapple with this very complex issue.

In our view, long-term control of health care costs will only be achieved by integration of prevention within the health care system. Our current model of health care is in reality the science of diagnosis and treatment. As a result, the system itself is a model of "crisis management," intervening after the fact with costly remedies rather than acting to anticipate and avoid the occurrence of ill health and disease. Under such a model, solutions

to contain costs can only have short-term impact because they do not cut to the core of the problem with our health care system. The adage of "an ounce of prevention" is indeed true, yet we have consistently failed, in any meaningful way, to integrate prevention into our health care policies and programs.

If a change is to be affected in our health care system to integrate the science of prevention, we must first impact upon the knowledge and attitudes of the individuals who run that system -- health professionals, particularly physicians. Unfortunately, today's average practicing physician has little or no comprehension of the potential role of preventive medicine in the practice of medicine. Frequently patients are more knowledgeable in this area than are their physicians. Yet there exists a body of knowledge which, if properly taught, could have a measurable impact on physicians' skills and, hence, the health of their patients. And here we speak of health in terms of health maintenance and the avoidance of costly disease, rather than treatment of it after the fact. In the aggregate, the implications for cost savings are potentially enormous.

Prevention, though a small field, is dynamic in its concepts and goals. Preventive medicine is the branch of medicine that is primarily concerned with preventing physical, mental and emotional disease and injury, in contrast to treating the sick and injured. The paramount goal of this area of specialization is to promote and preserve individual health status. Additionally, it is concerned with the well-being of the community, and the efficient and effective management of scarce resources.

The distinct body of knowledge known as preventive medicine can be traced at least to 1913, when the first edition of Rosenau's Preventive Medicine and Hygiene was published. Since that time the body of knowledge has been extended and its focus has shifted in response to changing patterns in the incidence of disease. For instance, early in this century, preventive medicine was concerned primarily with communicable diseases, while today one major focus is on chronic conditions such as respiratory and heart disease, while another is health maintenance and enhancement.

Training and practice in preventive medicine build upon a diverse, multi-disciplined base. The "core" sciences of preventive medicine include epidemiology, biostatistics, environmental health, nutrition, clinical preventive medicine, the behavioral sciences, management and health care systems analysis.

Preventive medicine practitioners are engaged in teaching, research, administration, and the delivery of personal health services. Teachers are responsible for instilling an awareness and knowledge of prevention in all medical students, through curriculum developed and taught by departments of preventive and community medicine, or through integrated curriculum in other clinical fields. Non-physician public health personnel are also trained by preventive medicine specialists within both medical and public health school settings. Researchers in the field are engaged in a wide array of activities, ranging from the study of risk factors and distribution of disease (epidemiology) to the design and evaluation of programs to promote health and prevent disease. Physician administrators occupy key positions in public and private settings, such as state and local health departments, and health maintenance

organizations, where they are responsible for planning and implementing personal and community health services. Finally, practitioners deliver a variety of prevention services in the community setting, be it the workplace, school, or locality.

In 1979 Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention called for a second public health revolution in the United States. In conducting such a campaign, the importance of prevention and the role of the physician specialist in preventive medicine cannot be overstated. While the incidence of chronic diseases is on the rise, a growing body of knowledge must now be translated into practice. Apart from tremendous returns in human productivity and cost savings, an investment in prevention promises the potential of avoidance of needless human suffering.

PREVENTIVE MEDICINE AND MEDICAL EDUCATION

Our present model of medical education in the United States was largely shaped by a famous report, which included the following among its observations:

"...The practitioner deals with facts of two categories. Chemistry, physics, biology enable him to apprehend one set; he needs a different perspective and apprehensive apparatus to deal with the other, subtle elements. Specific preparation is in this direction much more difficult; one must rely for the requisite insight and sympathy on a varied and enlarging cultural experience. Such enlargement of

the physician's horizon is otherwise important, for scientific progress has greatly modified his ethical responsibility. His relation was formerly to his patient - at most to his patient's family; and it was almost altogether remedial. The patient had something the matter with him; the doctor was called in to cure it. Payment of a fee ended the transaction. But the physician's function is fast becoming social and preventive, rather than individual and curative. Upon him society relies to ascertain, and through measures essentially educational to enforce, the conditions that prevent disease and make positively for physical and moral well-being (emphasis added)...¹

To the intelligent and conscientious physician, a typhoid patient is not only a case, but a warning: his office is equally to heal the sick and to protect the well..."²

That was written in 1910, in the "Flexner Report" on Medical Education in the United States and Canada, a report which otherwise revolutioned the course of medical education, (in most respects.)

Fifteen years later, in a retrospective study of the 1910 report, Abraham Flexner wrote the following:

"Curiously enough, despite the increasing importance of preventive medicine, consequent

upon the advance of bacteriology and the clearer knowledge of the futility or limitations of many therapeutic measures, hygiene continues to occupy a decidedly subordinate position in the undergraduate curriculum; and even incidental treatment of the preventive aspects of disease, though increasingly³ common, is still far from general."

In 1932 a Commission on Medical Education of the Association of American Medical Colleges (AAMC) made the following observation:

"Medical education should emphasize to students the influences of urbanization, industrialization, and present day conditions of living which are important in the causation, treatment, and prevention of disease...it is important that the physician be acquainted with the social, economic, and other environmental factors which have an influence on the individual⁴ and his health."

In 1945, a Committee of the AAMC, formed to investigate the teaching of preventive medicine and public health in medical schools, again found severe shortcomings in this area. Among other things, the report examined the importance of a distinct department of preventive medicine, as well as the necessity of increasing the proportion of medical school curriculums devoted to prevention. Committee recommendations, which were approved by the AAMC Executive Committee, included:

"1. That the objective in each medical school be to provide a separate department of preventive medicine and public health and that for purposes of evaluating the organization for teaching preventive medicine and public health in any given school, the combination of preventive medicine and public health with some other department be regarded as unsatisfactory after July 1, 1948...

2. That there be set aside for the teaching schedule of the department of preventive medicine and public health, four percent of the total hours available in the curriculum of undergraduate medical education, and that after July 1, 1948, any medical school providing less than this amount be considered deficient in this regard...

5. That the various departments of the medical school in their respective fields, strive for the greatest practicable contribution in teaching the preventive aspects of disease; that in the highest degree possible, the teaching of preventive medicine and public health be integrated with clinical teaching,

and that the greater part of the instructional staff in the department of preventive medicine and public health be given hospital and clinic appointments." ⁵

In more recent years, both medical school curriculum and residency training in preventive medicine have been the subject of a number of studies. In 1975, a task force on Education and Training of Health Manpower for Prevention (National Conference on Preventive Medicine) found evidence of insufficient training of prevention within medical schools as well as shortages of specialty trained practitioners in the field. The task force recommended that federal health manpower legislation be enacted which would a) encourage a preventive emphasis on the basic curricula for health personnel b) provide career development support for training of teachers of prevention, and c) encourage projects to integrate prevention in programs to train primary health care personnel.

In 1978 these recommendations were confirmed by an Institute of Medicine report entitled A Manpower Policy for Primary Health Care. The report found that "...insufficient attention has been devoted to teaching and research in behavioral and social sciences, to the coordination and continuing of health care, and to clinical experience in

outpatient settings." It therefore recommended that

"Undergraduate medical education should provide students with a knowledge of epidemiology and aspects of behavioral and social sciences relevant to patient care."⁶

Last year the first Surgeon General's Report on Health Promotion and Disease Prevention was issued. In addition to proposing a strategy for the integration of prevention within our health care system, it discussed at length the manpower implications of such a strategy. Again, evidence of future shortages in the field of preventive medicine was cited, as well as an insufficient emphasis on prevention in the training of physicians.

In December 1979, the Department of Health, Education, and Welfare submitted a report to Congress on community and public health personnel. Among other things, this report contained the following recommendation for action by the Federal government:

"Encourage and support the development of capabilities to provide training in health promotion, disease prevention, and other public health content in the curriculum of schools of medicine, osteopathy, dentistry, optometry, pharmacy, podiatry, veterinary medicine, and in schools offering preparation in the allied health programs."⁷

Clearly there has been long-standing consensus that our health care system, particularly the educational system, should place greater emphasis on prevention. This consensus, however, is in stark contrast to current realities:

- * Of the nation's 122 medical schools, at last count only 88 have departments of preventive medicine or its equivalent. A number of these are today threatened with closure due to shrinking budgets. Others have already been forced to close down since the last count was made a year ago.

- * Federal support for generic special projects in preventive medicine within medical schools has dropped precipitiously, from \$1.1 million in FY 79 to zero in FY 80.

- * It has been estimated that less than 1.5% of the total undergraduate medical curriculum is devoted to prevention, in contrast to the 4% recommended above by the AAMC.

- * Of the 48 active accredited residency programs in preventive medicine, most have only a few funded positions

available. For 1978-79, the mean was 4.3 funded positions per program.

* Although it has been estimated that 6,800 preventive medicine specialists will be needed in 1990 to meet demand, at the current rate at which they are being graduated from residency training programs, only 3,300 will be available in that year, a shortfall of 125%.

* Federal support for residency training has also declined in recent years. Whereas in 1973 \$1.2 million was committed for this purpose, in 1978 and 1979 that level of support dropped approximately \$100,000. In FY 1980 approximately \$275,000 was made available for this purpose.

Although preventive medicine needs have been repeatedly stressed they have seldom been met. The reasons are obviously complex. Chief among these has been the minimal commitment of financial resources within medical schools to departments of preventive medicine. Without these resources, existing departments, even where they do exist, are unable to develop the faculty, and hence the curriculum, for long-term impact upon medical student education. Without that impact, we are unable to recruit new physicians into the field, further

exacerbating faculty development.

When medical students do express an interest in specializing in preventive medicine after graduation, they are faced with uncertain and fluctuating prospects for support during their residency training years. Many residency program directors resort to turning away prospective residents because the resources simply do not exist to support them. Government stipend support is particularly important for the preventive medicine resident because stipends cannot be provided out of patient care revenues as with other "bedded" specialties. An extra year of post-MD academic training is required for board certification. Preventive medicine residents are not hospital based during the remainder of their training, thus program directors cannot offset training expenses by providing services for remuneration. Finally, after graduation preventive medicine specialists generally occupy positions in the public health sector at salary levels which are much less lucrative than private practice, making repayment of educational loans much more onerous.

The current state of affairs has therefore led to extreme shortages in many preventive medicine areas. In addition to impacting on the delivery of public health programs and prevention research, this has obviously had an impact on the status of prevention within the medical school curriculum, thereby completing a vicious cycle. Without the required

manpower pool, advancement will be impossible. Certainly if our health care system is to place greater emphasis on prevention, a change must be effected in the attitudes and behavior of medical students and physicians. Federal manpower policy must foster an integration of prevention principles within manpower education. The commitment must be made now to develop the necessary manpower base to carry out this mission, and we applaud you, Mr. Chairman, for your leadership in this regard.

We are, therefore, pleased that HR 2004 contains authority for support for both departments of preventive medicine and residency training in preventive medicine. These authorities will provide a stable base to attract talent and resources into this vital field.

The provisions contained in Section 794(C) of HR 2004 are all equally important. First, it is important to provide stable, generic support for the activities of the departments which is not tied to a specific purpose. In this way departments will have a resource to draw upon for innovative projects and activities. Section 794(C)(a)(3) will support vital updating of the curriculum in the core knowledge areas of preventive medicine, because it authorizes projects to strengthen the preventive medicine interface with the other clinical specialties. Besides being a specialty area of knowledge, prevention also has multidisciplinary aspects which need to be integrated into other clinical specialties. Finally, support for programs to train teachers and researchers, as authorized in Section 794(C)(a)(4) is particularly crucial. These programs will expand a faculty base which has been drastically reduced in recent years because of diminished investment.

Confronting, as we do, a future of diminished resources which must be allocated among competing demands, it is important that we invest wisely with an eye to future returns. As health care costs have skyrocketed in recent years, alternative forms of cost containment have been examined. None offers more promise than prevention. Clearly, if the goals of our health care system is to assure optimal health at minimal cost, disease prevention holds an important key. HR 2004 will therefore provide the opportunity to unlock and apply knowledge which from as far back as 1910 has been generally recognized as being vital to our nation's health and well-being.

Footnotes

- 1 Medical Education in the United States and Canada, The Carnegie Foundation for the Advancement of Teaching, N.Y., N.Y., 1910, p. 26
- 2 Ibid., p. 68
- 3 Flexner, Abraham, Medical Education: A Comparative Study, MacMillan Co. N.Y., N.Y. 1925, p. 117
- 4 Final Report of the Commission on Medical Education, Association of American Medical Colleges, N.Y., N.Y. 1932
- 5 Final Report of the Committee on the Teaching of Preventive Medicine and Public Health, Journal of the Association of American Medical Colleges, Vol. 20, 1945
- 6 A Manpower Policy for Primary Health Care, Institute of Medicine Washington, D.C. 1978, pp. 77, 101
- 7 A Report on Public and Community Health Personnel, U.S. Dept. of Health, Education and Welfare, 1979, p. VII-8

Mr. WAXMAN. Thank you very much for your testimony.

Dr. Rabin, in the area of schools of public health the graduates don't go into a profession where their earnings are as great as the graduates of the medical schools. One of the arguments that they make, in addition to the fact that all three of your programs are in the area of prevention or disease, is that because their professionals earn less money they need this financial assistance to the schools.

On the other hand, doctors are one of the highest paid groups in our society today. Why couldn't we expect the medical community to try to put the emphasis on paying for this preventive medicine?

Dr. RABIN. I think that would be admirable and I am very much in favor of having the medical community provide preventive services in the context that they usually provide services, when they see individual patients. Unfortunately, we know now that many physicians are not as knowledgeable and do not provide as much a volume of these preventive services as would be desirable.

One major reason for this is that they have not previously been educated to provide these services. It is to this point that we wish to address ourselves and wish to justify the support of preventive teaching in medical schools.

Mr. WAXMAN. Wouldn't the medical colleges want to teach preventive medicine as part of training better rounded physicians to practice and to be able to handle the whole needs of their patients?

Dr. RABIN. Yes; I think they should want to. They should want to as well provide physicians who are as well trained in providing curative services as possible. From the medical schools' perspective it is a question, at a time of their being under major fiscal constraints, what is within their capability, what is affordable for them and what is most important for them to do.

Within the context of decisionmaking that is made within medical schools, the interests, the concern and the value is to meet the urgent needs of ill patients. Therefore as medical schools are increasingly concerned as Federal and State support for medical education drops, as tuition becomes higher and students can progressively less afford it, to the expenses of medical education.

A major area in which there is a cutback in medical education is in that area in which medical schools are least supported for, which is the training in prevention.

I would share the feeling that you have but the reality is that schools tend to cutback, as do individual physicians, unfortunately, on those areas that seem to be least remunerative.

Mr. WAXMAN. The administration is recommending we cut special projects money and the traineeships programs. Tell us more about those two programs and what value they serve or whether you could live without them. Not whether you would like to live without them but whether you can live without them.

Mr. GEMMELL. To be honestly frank, Mr. Chairman, the recision of 81 traineeship funds to students in schools of public health is—I will use the term “disastrous.” In fact, these midcareer individuals have stopped working and gone back to school to get their master's degree in public health and hope in a couple of years to go back.

Now, most of these individuals, Mr. Chairman, have previous loan commitments from previous education. Most are midcareer

and most of them have important family obligations. So this is an incentive and it is not a big incentive. The average traineeship award is less than a thousand dollars per student.

It is an incentive for them to interrupt their public service to get advanced training in a U.S. public health school graduate school so that they can go back to contribute their skills in an improved environment.

Now special projects has been rescinded only \$2.5 million out of \$5 million, Mr. Chairman, and these projects are used to upgrade curriculum. We always hear complaints about faculty not being up to speed on the newest and latest technological developments in the field of medicine or public health. These special projects enable those faculty members to do those sorts of things and some of the special projects, Mr. Chairman, are used to provide services in the community.

Mr. WAXMAN. Thank you.

Dr. Sundre, do you want to comment on that?

Dr. SUNDRE. Yes; thank you. I would echo what Mr. Gemmell said regarding traineeships for public health as a similar case in health administration in that the entitlements supporting these traineeships is barely 3 years old at this point is just beginning to show a return on investment, if you will, in terms of generating additional management talent for the field.

Furthermore, we face a situation whereby the typical traineeship recipient is an individual somewhere around 30 years of age with one or two dependents who has left a position in one of the clinical sciences to, if you will, pursue a career in management.

To discontinue support at this point, particularly for those students who are currently in their first year and will be moving to their second and final year next year is something that I think represents a commitment that we must deal with.

Mr. WAXMAN. Thank you very much.

Mr. Madigan.

Mr. MADIGAN. Mr. Gemmell, in response to the chairman when he asked you about rescinding the funding for traineeships you said that would be disastrous. Then you went on to say as you elaborated on your remarks that, after all, that support doesn't amount to very much per individual, that it was on an average a thousand dollars per student. How can something that doesn't amount to very much be disastrous?

Mr. GEMMELL. Perhaps I was a little bit too hasty in using the term disastrous. I was trying to express a feeling that most of these students who are hoping to receive continued traineeship support in the fall, that we, as a Federal policy, have made a commitment to these students for at least 2 years and now that money has been threatened to be cut off in mid-stream, if you will. So I would say disastrous more in terms of not keeping up to a commitment that this country made to these students who have gone back to study, graduate and continue working in the field of public health service. Maybe I used the term a little bit too hastily, Mr. Madigan.

Mr. MADIGAN. Well, actually as a result of having that advanced degree are they not ultimately the financial beneficiaries of having that master's degree? Doesn't that enable them in most cases to earn a higher salary?

Mr. GEMMELL. We have a recent survey of 1978 and 1979 graduates. Most of them prior to entering graduate school were earning in the neighborhood of \$18 to \$19 thousand a year. When they re-entered back into public health work their salary went up about maybe a thousand dollars or so. After 15 years of service our survey shows that the average salary of a public health worker is about \$30,000 a year. So working in the field of public health doesn't increase dramatically their income power.

Mr. MADIGAN. That would seem to suggest, and I am not debating this with you but I am trying to understand these things because they are all new to me, on the basis of what you have said, that whoever is employing these people and whoever is establishing these salary schedules must think that an advanced degree then is not worth very much. I assume from what you had said that if the person with the undergraduate degree continued to be employed, as opposed to going back for a master's degree, that at year 30 the salaries of the two people would be about the same, the one with the undergraduate degree and the one with the advanced degree. Is that correct?

Mr. GEMMELL. We are talking about averages now, Mr. Madigan, and I would agree with you to a certain extent. But the reason is why people go back is because this is an advancement within their career ladders. That is the magic ticket in the field of public health to have a master's in public health just like it is a ticket to have a Ph.D. if you are an academician. So this is an advancement at mid-career. For example, instead of being just a worker in the epidemiological department, this person might direct it or be a deputy director of the department of epidemiology.

Of course, these are average salaries and I am not suggesting that everybody in public health would make only \$30,000 a year after 15 to 20 years of experience. These are just general averages that our surveys have shown and our surveys are about 2 years old. So we could increase that. If you want to put it in constant dollars versus the current dollars we can add, and I don't know what the GNP deflator is right now off the top of my head, but we can increase those salaries.

So I don't mean to suggest that all of them are basically underpaid, but what I am saying is on the average you only have approximately 100,000 public health workers in this country right now who have gone to a school of public health.

Mr. MADIGAN. You have confused me again, and it is not because you are doing that deliberately but it is because I have so much trouble understanding this and I apologize for that. But as I understand now in summary what you have just said, this master's degree doesn't make you any more money necessarily but it is a magic ticket to something.

I think what you said is that it is a magic ticket to a better job, the director of the department.

Mr. GEMMELL. That is correct.

Mr. MADIGAN. That surely pays more, does it not? I think what you said is that it is a magic ticket to a better job, the director of the department.

Mr. GEMMELL. That is correct.

Mr. MADIGAN. That surely pays more, does it not?

Mr. GEMMELL. That is correct. That is why I said these salaries are just averages, Mr. Madigan. They are averages. They can range all the way from \$10,000 all the way up to \$60,000. So these are just averages of all of our graduates after 15 years experience.

Mr. MADIGAN. So if it does pay more, and have we agreed that it does pay more?

Mr. GEMMELL. Yes, sir, it does pay more.

Mr. MADIGAN. Then it would be a good investment of a person's own money, would it not, if the ultimate result of that is that they are going to be able to earn more money and have a better job, a job with more social status and more responsibility and more income?

Mr. GEMMELL. I would agree with you that that is correct. However, how are you going to get a person who is in mid-career, who is 30 years old with previous debt commitments from education in undergraduate school with dependents to interrupt their career in order to go back into a school of public health so they can beef up their management skills and then contribute more to the provision of public health services which will benefit the community, benefit the State, and benefit the Nation as a whole? It is an incentive, Mr. Madigan, to come back to school.

Mr. MADIGAN. Let me present it to you from the taxpayers' point of view. We have in the last 7 years through deficit budgets gone in debt as much as we did the previous 200 years. The interest on what we owe is now the third largest item in the budget. It is going to be \$100 billion this year. We are borrowing the money to do these kinds of things.

From the taxpayers' point of view why should the taxpayer put out some incentive to this person to interrupt his career to go back to school so that he can get a better job and make more money? Why should that be the responsibility of the taxpayer to do that?

Mr. GEMMELL. It depends on your point of view philosophically in terms of how you define public health. We define public health as a public responsibility that has been traditionally supported by tax dollars because the services look at the community as a patient and not the individual as a patient.

Therefore, these services, Mr. Madigan, aren't reimbursed from a traditional third-party fee-for-service reimbursement system. It has been a tradition in this country that State, local, and Federal Governments contribute to the training and the providing of public health services in this country. If the government doesn't provide for it then it won't be provided because public health is not a fee-for-service third-party reimbursement service.

This is what Dr. Rabin was talking about earlier that the reason why preventive medicine in public health aren't that popular in medical schools. It is a simple matter. These services aren't reimbursed under medicare and medicaid or Blue Cross/Blue Shield. So the money must come from somewhere and traditionally it has been through public tax-supported programs.

The Federal Government's share in public health, Mr. Madigan, is very small. It is only less than 5 percent of the total cost of teaching an MPH for 1 year which costs around \$10,000 a year. So we are not talking about a lot of money. It is just the Federal share we believe along with the universities, along with the States and in

some cases local communities, the Federal share of the cost that it takes to train a public health worker.

Mr. MADIGAN. I am afraid everything you say provokes further philosophical argument from me, but I am not going to belabor it because we are trying to get through a lot of witnesses here.

I would just say to you that there is a determination on the part of people elected to the Federal Government this year to bring this budget under control and you ought to be aware of that.

Mr. GEMMELL. We are very aware of it, Mr. Madigan.

Mr. MADIGAN. If you have suggestions as to how we can better utilize a lesser amount of money we would certainly be receptive to hearing from you.

Mr. GEMMELL. Thank you very much.

Mr. SHELBY [presiding]. Ms. Mikulski.

Ms. MIKULSKI. Thank you very much, Mr. Chairman.

My question is to Mr. Gemmell. Could you give me a student profile of the average MPH person from the standpoint of gender, race, and economic background? The panel that we heard earlier was focused on disadvantaged students. We're talking now about this 30-year-old with two dependents. Could you tell me with a little bit more specificity who that is?

Mr. GEMMELL. Ms. Mikulski, our recent survey which was the 1979 survey showed that over 51 percent of the students in graduate schools of public health were women. Over 10 percent were minorities. Back in our offices we have a complete breakdown of all the characteristics of the students and the faculty members and the programs in the schools of public health.

Ms. MIKULSKI. So what you are saying is that there are a great many women who are pursuing an MPH.

Mr. GEMMELL. That is correct.

Ms. MIKULSKI. But in terms of minority participation, for example, blacks and Hispanics, that is at a 10 percent level?

Mr. GEMMELL. A combined 10 percent.

Ms. MIKULSKI. Are the women coming to pursue an MPH primarily women with a nursing background?

Mr. GEMMELL. A lot of them have been nurses or are nurses.

Ms. MIKULSKI. In other words, you just don't go to get an MPH; you usually come from some other provider field?

Mr. GEMMELL. Another field, yes, ma'am. I would probably guess off the top of my head, and I will have to get you this data that we have back in our office, but I would say that 10 percent of the women entering schools of public health are nurses.

Ms. MIKULSKI. I see. This takes me then to something else as one calculates minority participation, which is usually done on the basis of race. Could you tell me how many foreign students are in schools of public health administration? Do they also count toward that 10 percent minority participation or is that a separate category?

Mr. GEMMELL. It is a separate category.

Ms. MIKULSKI. This is not an isolationist statement and please don't get me wrong, but I am trying to see who are we educating and who are we contributing to. What about the foreign student population in our program—do they pay tuition differentials?

Mr. GEMMELL. They pay the same tuition that is required of the U.S. student but these students do not receive Federal assistance whatsoever. It depends on the school. Hopkins, for example, its student body is probably 5 to 10 percent foreign students. When I say foreign students, I mean individuals who come to the United States to train and generally end up in positions of authority back in their home country.

Ms. MIKULSKI. That is right.

Mr. GEMMELL. The Hopkins School of Public Health has been known to do this, to train health ministers. They come over to this country to learn the techniques of public health.

Ms. MIKULSKI. That is fine. But in addition to why they come, how many are there? Are there a lot of foreign students?

Mr. GEMMELL. I would again probably say 5 percent of the student bodies of 7,000 students in schools of public health are foreign nationals.

Ms. MIKULSKI. Then that takes me then to another question because you say that even though the foreign students don't benefit from scholarships, there are capitation grants. Now the issue becomes, as we decide how to spend Federal dollars, of where can we do the most good? Is it giving money to the institution or giving money to a student to be able to attend the institution?

Mr. GEMMELL. Traditionally, institutional support has meant a lot to the schools of public health because it is that money that ties the school together, Ms. Mikulski. What we use institutional support for is to make the school a school because it is, and I am going to use the expression "barnyard" of various categorical programs each with their own basis of leadership and support. So institutional support is that money which the dean utilizes, one, to bring the disciplines together around a common objective, that is to train a total comprehensive public health workers as opposed to an epidemiologist that goes merrily on his course. But instead that capitation or institutional support is used to bring together the major categories within the school to produce a total public health worker.

Ms. MIKULSKI. All right. There are two questions I would like to pursue on that, and then I will end my questioning.

It seems that, from what you are saying, that the reason you need aid to institutions, is because these graduates do not enter highly remunerative fields, and thus your institutions don't end up with big endowments.

In other words, somebody who is working in Iowa in epidemiology isn't going to leave Hopkins a bundle of bucks, which also holds true for schools of nursing. In other words, those institutions, though training highly specialized people, produces graduates who are not wealthy and therefore don't leave endowments. So in that sense, the very people that you train necessitate the capitation grant.

Mr. GEMMELL. That is correct.

Ms. MIKULSKI. That would also hold true for nursing. Then that takes me to something else, though, about capitation grants and the deans making these wonderful decisions.

One of the things that concerns me as I have looked at schools of public health—and by the way I am a supporter of them for exact-

ly what you said. More people are probably going to die because of obesity or from drunk driving than some esoteric disease. But my concern is that the schools of public health from what I have seen are moving more and more away from training people for service or their own faculty and moving into what I refer to as grant junkies.

In other words, there is a lot of energy that goes into pursuing more and more research, usually of a very fragmented, narrow and sometimes esoteric level. So that the students are trained to be researchers to get more Federal funds than to be out there in Iowa trying to figure out what to do about malnutrition among poor people or whatever.

My question to you is if we give deans that money, are we going to end up training more people to sit around congratulating each other at conferences on the latest research grant they have gotten?

I am really hot about this because Hopkins dropped the nurse midwife program at its institution because it said it was only oriented to service and had no research money in it. And you have got to know I am still pretty damn mad about that and that is applicable to a variety of other programs across the board as I began to look at them not only at Hopkins but at other institutions—and I am not interested in training people to do that.

Mr. GEMMELL. We are extremely aware of that. One of the things we have been doing in the last 2 years is developing a closer relationship with the Association of State and Local Health Officials in this country. We are meeting next month with these officials so that the health officers can tell our faculty exactly what needs to be done and what is really happening out in the field and we agree with you a hundred percent on that.

Ms. MIKULSKI. How would you structure the grandstand so that money goes into training people to do something rather than sitting around consulting about something?

Mr. GEMMELL. Through the special projects approach with certain federally mandated areas of investigation and service delivery.

Ms. MIKULSKI. Well, I would like to see that and I would welcome some language from your organization because in looking through some of the other testimony I see that we are talking here about curricula and health marketing and things like that. I mean, it really doesn't excite my support.

Mr. GEMMELL. Again, the schools have three services, teaching, research and community service, and you are talking about community service. That again is where we don't have that magic reimbursement mechanism to provide for those services. The only way it is going to get reimbursed is through State and through Federal contribution into these community public health services.

Ms. MIKULSKI. Mr. Chairman, I have no further questions.

Mr. SHELBY. Thank you.

Mr. Bliley.

Mr. BLILEY. Thank you, sir.

Dr. Rabin, you made a comment that I found interesting. I believe it is exceptionally honest and I thank you for it. You indicated that homeopathic medicine which is your discipline is oriented toward diagnosis, curative work and that preventive medicine really is a new field outside of the traditional. I think

that is quite true, it is outside the field of homeopathic medicine. That is much more the line of the osteopathic schools where they concentrate on family practice and preventive fields of medicine.

My question is why should we support homeopathic medical schools which have no tradition and have not been willing to use their own funds for preventative programs? Would it not make more sense in a time of limited resources to channel our few funds into schools of osteopathy where they do have some tradition?

Dr. RABIN. There is at the present time now one school of osteopathy which is unequivocally committed to developing a 4-year curriculum related to prevention. Other schools of osteopathy are less completely so committed. Many indeed don't even have a department of preventive medicine. Most don't. Most people in regular medicine go into the field of primary care within the practice of medicine.

There has been a great emphasis and a substantial response by regular medical schools in terms of training their young physicians, and increasingly training their physicians so that they will go into primary care. Primary care is the area in which most physicians have contact with patients. That is where most well patients will present and patients who have a chronic disease in an early stage will be seen, at which time prevention is applicable.

Physicians in primary care do provide the preventive services that are provided by physicians. On a percentage basis the most common single reason for a person's visit to a physician is for some preventive service.

I think what we wish to do, prevention is important to do, since about 95 percent of patients seen by physicians or osteopaths are seen by regular physicians, educational support is needed to be sure that in the nature of that particular contact one has a provider, be he or she an osteopath or a physician, who is able to be responsive and effective in providing the appropriate service which often is prevention.

Furthermore I think it is terribly important for most osteopaths and physicians to have some small proportion of that group, and to my knowledge the small proportion that does exist in this area is almost exclusively M.D.'s, go on into a full-time career in the area of preventive medicine and serve the community basically on a total commitment in the area of prevention.

Mr. BLILEY. Mr. Gemmell, could you help us, please in how much of a role these Federal funds play in your budget and how much comes from State and how much comes from tuition of the students?

Mr. GEMMELL. There are 21 schools of public health.

Mr. BLILEY. Just in round numbers.

Mr. GEMMELL. Seven of them are private institutions. The private institutions receive almost zero support from State governments. So Federal support in that category, and in fact I have the facts here that I could show you later on, but in the private schools it is about 10 to 12 percent of their budget.

In the State schools that are supported but not highly supported because they are regional centers and it is really tough for a dean to go before the State legislature and argue successfully that the State of Minnesota should support a student body that is comprised

of only 20 percent Minnesotans and the rest from the region in the west.

So it is tough for the deans to go to the State legislatures. Those where the State does contribute it is, oh, about 8 to 10 percent of the total budget. Those are general figures, and again we have them and we can share them with the committee as to the specific breakdown in those exact categories.

Mr. BLILEY. But about 10 to 12 percent is about the Federal share. What does that translate into dollars, \$1,000 or \$1,500 a year per student?

Mr. GEMMELL. About \$1,000 per student.

Mr. BLILEY. So if the Federal share is reduced it would be then necessary for a student, say, to pick up \$500 from the State or something of that nature?

Mr. GEMMELL. I guess if you put it that way that is correct, but the problem of orchestrating such a large number of 21 schools and 7,000 students to come up with the end result would be almost impossible to do.

Mr. BLILEY. Thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Luken.

Mr. LUKEN. Dr. Rabin, I would just like to pursue for a moment the philosophical exchange that the gentleman from Illinois initiated here.

I would like to first observe that serving the public does not always pay financial rewards. I think this ought to be pretty well known to the members of this body. I think that the gentleman's questions were based upon the premise that there are financial rewards in any profession and that increase in proficiency and education will increase the financial rewards.

I would like to ask a question. This is public health and many or most of the people we are talking about training or advancing in skills are going to be working for governmental bodies or agencies; isn't that right?

Mr. GEMMELL. That is correct.

Mr. LUKEN. Since we are a governmental agency here it would not be out of sync, would it, for a governmental agency as an employer to provide educational opportunities to advance that employee's skills in a particular field even though there would be the side effect that that employee would, as a result of obtaining that experience and education, attain a better job.

For example, we see the ads on the television all the time about joining the Army or the Navy and becoming more proficient. They get promotions along with it but are also serving a public purpose. Isn't that what we are talking about?

Mr. GEMMELL. Yes, Mr. Luken. You said it very well.

Mr. LUKEN. I am really not making a speech in this regard, but are you losing people to alternative programs? Is there a danger of losing people to other medical fields if they do not continue to progress in the public health field through educational programs such as are provided here?

Mr. GEMMELL. Most of the individuals with a baccalaureate degree in say math who could be trained to be a biostatistician if he or she took 2 years off to enter into this very complicated field

without the Federal incentive and without the traineeship support he or she would probably go into other fields outside of public health mainly in proprietary area and I am not knocking that.

What I am saying is that because of the field of public health, Mr. Luken, and its unattractiveness for a lot of reasons, money-wise and a traditional concern with communicable diseases, and we are over that hump now because we have those fairly well under control and nobody can say that we have not done a good job in smallpox and measles and polio and things like this. What I am saying is now we are going into the hardest phase of public health which is the control and prevention of chronic diseases and that requires a little bit more advanced training in schools of public health. So the Federal support is the little incentive that we need.

Mr. LUKEN. If I may interrupt. There is no way to provide financial incentives for that. We have not devised financial incentives for progressing in this field, have we?

Mr. GEMMELL. There is no third-party reimbursement policies for services to the community to prevent the spread of disease.

Mr. LUKEN. So if we are serious in representing the entire population in controlling the spread of disease by epidemiology, in such pursuits we have the sole responsibility. Since we can't provide any financial incentives we expect that the people are just going to naturally rise to the heights in accomplishing these goals. Isn't that what we are saying?

Mr. GEMMELL. Yes, sir. It seems to me that we do have a problem since there well may be and there are going to be limited Federal dollars in balancing these things out. I guess another aspect is, and I think it has been suggested by some questions here, but there is the alternative that the individuals in the program might not stay in the program or might not advance in the program.

Mr. LUKEN. I guess another alternative is that the local government could pick up the slack if it would, right?

Mr. GEMMELL. If it would.

Mr. LUKEN. Coming from local government I recognize that is a big if. As usually is the case, the reason the Federal dollars are there is that the local government is not willing to. I think we have found that all across the board. Even where the Federal dollars initiated some good programs the local governments have rarely continued them. Is that true?

Mr. GEMMELL. That is correct. If I might add just one more thing. The reason why is because most of these people that we train work to implement federally mandated programs, clean air, clean water, communicable diseases and all the Public Health Service programs. Therefore they work at the local level in response to a Federal initiative.

So that is another twist that makes the locals say, well, if it is a Federal program and they are implementing Federal programs let's let the feds pay for it. So it is a two-way battle. I think it is a partnership, it is a partnership effort because these are national programs that should be implemented in equal partnership with the Federal Government, State government, local government and the universities. So it is kind of a two-way street. I can speak with a little bit of authority since I represented the counties for 10 years.

Mr. LUKEN. Well, we have the additional problem here, as suggested by the gentlelady from Maryland, that even the ultimate consumers who are our constituents, have difficulty in relating to research and the control of disease and so on, whereas they have a far easier time relating to the delivery of service.

But if we are the only agency that is going to provide this, and that seems to be the story that you are giving, then I think we have a particular problem.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Luken.

Dr. Rabin, Mr. Gemmell, and Dr. Sundre, thank you very much for your testimony.

Due to a scheduling problem our next witness will be out of the order listed in our schedule. We will now call forward Dr. William Ruhe, senior vice president of the American Medical Association.

Dr. Ruhe, we are delighted to have you with us today. We would like you to summarize your statement in no more than 5 minutes, sir.

STATEMENT OF C. H. WILLIAM RUHE, M.D., SENIOR VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY BRUCE BLEHART, LEGISLATIVE DEPARTMENT

Dr. RUHE. Thank you, Mr. Chairman.

I appreciate the opportunity to appear at this time before the committee. I will try to be brief.

Mr. Bruce Blehart from our legislative department is with me.

The AMA views two factors as being singularly important to assuring the strength of the medical education system. First, the institutions themselves must have sufficient resources to provide education of high quality, and second, the students who wish to pursue careers in health professions must have the resources to meet the costs of this education.

As far as institutional support is concerned, the AMA strongly endorses the concept of having multiple mechanisms for aiding medical schools. In addition to the aid which has been available through Federal programs under the Public Health Service Act, State aid to many health professions and educational institutions has proven invaluable.

General institutional support represents an investment of public funds that have successfully aided in improving the quality and availability of medical education and medical care. However, even these expenditures must be reviewed in light of competing priorities for limited resources.

Special project grants have also proven to be beneficial. In authorizing grant moneys the Government has succeeded in furthering important goals such as the bolstering of primary medical care in the United States.

Funds for aiding institutions in financial distress and for the modernization of existing facilities have an immeasurable value as a means of maintaining the quality of medical education. Such funding should take precedence over any future Federal investment in the startup of new medical schools.

However, in supporting Federal assistance for modernization of existing facilities and for institutions in financial distress the AMA

recognizes that Federal funds cannot act as a permanent crutch for schools in need of modernization or in financial distress.

In light of the reductions in institutional support for medical schools previously approved by this committee and the House of Representatives, it is our view that the medical community and the medical schools must diversify sources of financial support for medical education. While the Federal role has been significant in the last decade, medical education has also enjoyed support from various other sectors of society.

STUDENT ASSISTANCE

The cost of financing a medical education can only be described as staggering. Annual tuition figures in excess of \$10,000 are becoming commonplace and we are deeply concerned over the financial burdens being placed on students and the impact of high tuition upon new practitioners.

The AMA believes that medical education must not be allowed to become limited on the basis of income. Student assistance must be of the highest priority for Government action. Financial aid must be available to make a career choice in medicine a viable one for qualified applicants. The AMA is committed to seeing that financial resources are available to qualified aspiring health professionals.

We believe that an effective and appropriate mechanism for Government participation is a program of guaranteed loans. Such a guaranteed program encourages private lenders to make money available to students and serves to minimize the strain on Government resources.

The AMA recommends that repayment of loans under such a program should be deferrable during the period of medical school training as well as through residency training when financial limitations might pose a hardship in meeting loan obligations.

Consideration should also be given to interest subsidies for the length of training and to setting the rate of repayment to the ability of the individual to repay the principal of the loan.

Loan forgiveness arrangements at realistic rates of forgiveness entered into following completion of medical training when the graduate medical student can better assess the various available alternatives could encourage shortage-area service. This would result in the placement of physicians in properly designated shortage areas who are more likely to remain in the areas following fulfillment of their payback obligation.

While the AMA strongly endorses the guaranteed loan mechanism, we believe that additional mechanisms can and should be available to help finance medical education. For example, service arrangements such as the military scholarship program and financial grants in aid for able but economically disadvantaged students should be available.

I would like to say that we are in support of most of what Dr. Elliott and Dr. Sullivan presented to you earlier today. Furthermore, State aid to students in health professions educational institutions must be encouraged.

With regard to the Graduate Medical Education National Advisory Committee the AMA opposes the legislative provision for the statutory establishment of this body.

In completing its study GMENAC developed complex mathematical models to estimate physician supply and future requirements for physicians. These models are similar to those used for making economic projections and they are highly sensitive to changes in assumptions, data, and priorities.

Past experience with economic projections and with long-term medical manpower projections has proven that even the most scientific evaluation tool only aids in the ability to make a projection that is no more than an educated guess.

Our concern with the statutory enactment of GMENAC is that a substantial potential for misuse of the information generated by this organization is inherent. The methodologies used in the findings of GMENAC are highly controversial and are not universally accepted.

We are concerned that a statutory authorization of GMENAC may imply a congressional acceptance and ratification of GMENAC's work to date. The AMA strongly recommends that studies concerning graduate medical education and the supply of medical services be continued by organizations using a variety of models.

Before this committee today also is the foreign medical graduate legislation, H.R. 2056. We believe that it has the potential of eliminating inequities and problems in our Nation's dealings with foreign medical graduates. The AMA supports H.R. 2056. The bill would eliminate the board certification requirement for FMG's licensed to practice medicine by a State prior to January 1978. It extends substantial disruption waivers for FMG's participating in a program that heavily relies on FMG's to deliver medical care, and modifies length-of-stay requirements for participation in graduate medical education.

In reviewing the comments made today and in considering the impact of health manpower legislation on the future delivery of care, we strongly urge the committee to consider not only today's needs but the needs of the future.

The AMA would be pleased to work with the committee to aid in the development of legislation to continue appropriate Federal assistance for health manpower.

Thank you.

[Testimony resumes on p. 365.]

[Dr. Ruhe's prepared statement follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

before the

Subcommittee on Health and Environment
Committee on Energy and Commerce
United States House of Representatives

Re: Health Manpower Legislation; H.R. 2004

By C. H. William Ruhe, M.D.

March 12, 1981

Mr. Chairman and Members of the Committee:

My name is C.H. William Ruhe, M.D. and I am a Senior Vice-President of the American Medical Association. With me is Bruce Blehart, a member of the AMA Legislative Department.

At this point in time, barely one month after President Reagan has taken office, the need to pare the federal budget is being viewed as the number one priority to turn the country's economy around. We are also aware of the fact that the Administration has just recently presented its proposed detailed budget for health manpower programs. As these figures are available, the AMA will, just as I am sure the Committee will, place them under close scrutiny.

The AMA views two factors as being singularly important to assuring the strength of the medical educational system. First, the institutions themselves must have sufficient resources to provide education of high quality; and second, the students who wish to pursue careers in health

professions must have the resources to meet the costs of this education. In order to accomplish these goals, we believe that it is in the best interests of medical schools, the government, the medical profession, and especially patients, that the relationship between government and medicine be as constructive as possible. In the end, our paramount concern and goal must be the provision of high quality medical care.

Institutional Support

The separate legislation passed in the House and the Senate last year, and the bill currently before this Committee, offer aid to health professions schools through a variety of resources: general institutional support, special project grants, funds for renovation of existing school facilities, and financial distress grants. The AMA strongly endorses the concept of having multiple mechanisms for aiding medical schools. In addition to the aid which has been available through federal programs under the Public Health Service Act, state aid to many health professions educational institutions has proven invaluable.

General institutional support represents an investment of public funds that has successfully aided in improving the quality and availability of medical education and medical care. The expenditure of these grants has the advantage of allowing the schools to have the flexibility to meet their individual needs and the needs of the community they serve. However, even these expenditures must be reviewed in light of competing priorities for limited resources.

Special project grants have also proven to be beneficial. In authorizing grant monies, the government has succeeded in furthering important goals,

such as the bolstering of primary medical care in the United States. The availability of special project grants has benefited those institutions that have availed themselves of this source of funds.

Funds for aiding institutions in financial distress and for the modernization of existing facilities have an immeasurable value as a means of maintaining the quality of medical education. Without resources for these purposes, the ability of some medical schools to graduate a competent and qualified class would diminish. Such funding should take precedence over any future federal investment in the start-up of new medical schools. However, in supporting federal assistance for modernization of existing facilities and for institutions in financial distress, the AMA recognizes that federal funds cannot act as a permanent crutch for schools in need of modernization or in financial distress.

In light of the reductions in institutional support for medical schools previously approved by this Committee and the House of Representatives, it is our view that the medical community and the medical schools must diversify sources of financial support for medical education. While the federal role has been significant in the last decade, medical education has also enjoyed support from various other sectors of society. It will now be incumbent to increase this latter base of support to assist in meeting funding requirements.

Student Assistance

The cost of financing a medical education can only be described as staggering. Annual tuition figures in excess of \$10,000 are becoming

commonplace, and we are deeply concerned over the financial burdens being placed on students and the impact of high tuition upon new practitioners.

The AMA believes that medical education must not be allowed to become limited on the basis of income. Student assistance must be of the highest priority for government action. Financial aid must be available to make a career choice in medicine a viable one for qualified applicants. Without such aid, the potential exists for medical education to become the privilege of the wealthy. The AMA is committed to seeing that financial resources are available to qualified aspiring health professionals.

We believe that an effective and appropriate mechanism for government participation in medical education is a program of guaranteed loans. Such a guarantee program encourages private lenders to make money available to students and serves to minimize the strain on government resources. The AMA recommends that repayment of loans under such a program be deferrable during the period of medical school training, as well as through residency training, when financial limitations might pose a hardship in meeting loan obligations. Consideration should also be given to interest subsidies for the length of training, and to setting the rate of repayment to the ability of the individual to repay the principal of the loan. Loan forgiveness arrangements, at realistic rates of forgiveness, entered into following completion of medical training when the graduate medical student can better assess the various available alternatives, could encourage shortage

area service. This would result in the placement of physicians in properly designated shortage areas who are more likely to remain in the area following fulfillment of their payback obligation.

While the AMA strongly endorses the guaranteed loan mechanism, we believe that additional mechanisms can, and should be available to help finance medical education. For example, service arrangements, such as the military scholarship programs and financial grants-in-aid for able but economically disadvantaged students should be available. Furthermore, state aid to students in health professions educational institutions must be encouraged.

Nurse Training

On a daily basis, physicians providing service to patients in hospitals are working under a handicap of a shortage of qualified nursing staff. The AMA supports continued federal assistance to programs of basic nurse training in order to meet the nation's nursing needs. This assistance should be provided to both the training institution and to the nursing student.

Graduate Medical Education National Advisory Committee (GMENAC)

When the AMA last appeared before this Committee, we testified that caution should be taken before establishing GMENAC as a permanent statutory entity. Now that additional time has elapsed since the issuance of GMENAC's final report, we, and other organizations, have had an opportunity to review this report. Mr. Chairman, we oppose the legislative provision for the statutory establishment of this body.

In completing its study, GMENAC developed complex mathematical models to estimate physician supply and future requirements for physicians. These models are similar to those used for making economic projections, and they are highly sensitive to changes in assumptions, data, and priorities. Past experience with economic projections and with long-term medical manpower projections has proven that even the most scientific evaluation tool only aids in the ability to make an educated guess that is no more than a projection. Our concern with the statutory enactment of GMENAC is that a substantial potential for misuse of the information generated by this organization is inherent. The methodologies used and the findings of GMENAC are highly controversial and are not universally accepted. We are concerned that a statutory authorization of GMENAC may imply Congressional acceptance and ratification of GMENAC's work to date. The AMA strongly recommends that studies concerning graduate medical education and the supply of medical services be continued by organizations using a variety of models.

CONCLUSION

Mr. Chairman, the American Medical Association would like to reserve an opportunity to submit additional comments for the record on the specific legislative proposals of H.R. 2004 after we have had an opportunity to review and analyze the Administration's recommendations in this area. I would like to thank you again for this opportunity to present the views of the AMA on health manpower issues and legislation. In reviewing the comments made today, and in considering the impact of health manpower legislation on the future delivery of medical care, we strongly urge the Committee to

consider not only today's needs but the needs of the future. The American Medical Association would be pleased to work with the Committee to aid in the development of legislation to continue appropriate federal assistance for health manpower.

At this time, I would be pleased to respond to questions that the Committee may have.

Mr. WAXMAN. Thank you very much for that statement. We certainly do want to work with you to develop this important legislation.

I just have one question of you. In the last Congress the Senate came up with a proposal for a student loan program for which the students would then be subject to being drafted to serve in underserved areas. I wondered if the AMA had a position on that proposal?

Dr. RUHE. We don't like the concept of the so-called indentured service. I think the main reason that we don't is that we feel that the students at the time they enter into these agreements are really not qualified to know what they are promising to do for the future.

We do believe, as we stated in the statement here, that there might be some provision for relief of the indebtedness load for students who at the time of completing their medical education or even their graduate medical education would be willing to enter into that service with a full understanding of what they are doing and where they are going at that point.

Mr. WAXMAN. But voluntarily only.

Dr. RUHE. Well, it would be at that point, yes. It would be voluntary until the point where they decided to enter into the agreement.

I think the thing that bothers us about the provision is that the individuals are asked to make the agreement at a time when we feel they are not really in a position to know what they are agreeing to do and they do it to grasp at the straw of financial support at a time when they need it very desperately.

Mr. WAXMAN. Well, I certainly agree with you. What bothered me was that they were agreeing not to anything specific but taking a chance that they would not be drafted and then have their loan paid back at the end of that time. It would seem to me that this would not engender the most dedicated person to go into an underserved area. They would probably feel quite bitter if they were drafted and understandably so.

Dr. RUHE. And you are talking about a period which may be 8 or 10 years down the road when conditions have changed considerably and what they are called upon to do may be quite different from what they had anticipated at the time they entered into the agreement.

Mr. WAXMAN. Thank you very much.

Mr. Madigan.

Mr. MADIGAN. Doctor, if I may just continue with you for just a moment the discussion we were having with the previous witnesses. If a person works for the Federal Government and is a GS-14, that is a GS-14 whether working in public health or drug enforcement or wherever they happen to be. If they worked for the equivalent of civil service in State government they are step 4 or step 5 or whatever the description is regardless of which department they happen to be in. The salaries are all the same whether they are working in the Environmental Protection Agency or the Department of Public Health or the Department of Law Enforcement or wherever it is that they are.

With that background does your organization believe that we can continue to justify additional financial support for advanced degree acquisition for people in public health to the exclusion of people in any other kind of educational pursuits?

Dr. RUHE. Well, it is a very difficult question to answer and I am not sure that I am qualified to answer for the field of public health. I think that the people who are in that field have a much clearer perception of what their problems are and the problems of the recruitment of students and the problems of advancing the art and the science of the field of public health.

I think we are obviously in a time when priorities have to be assigned to everything. That makes it a very difficult case to prove and I think there is a necessity for showing that the problem which is being proposed is going to produce something positive and beneficial to society and which will probably not be available unless it is proposed.

Now, beyond making that general observation I really don't think I have anything to say about the specific advanced degrees in the public health field. This has been a rather confused field for many years and it has not had clearly identifiable missions and goals in many cases.

There are segments of the field where there are clear goals and clear pathways for advancement. There are others where it is much more general and much more intangible. I think there has to be some sorting out of the missions and goals in order to justify specific programs. Beyond that I guess I am not qualified really to answer the question.

Mr. MADIGAN. I think that was a very good answer.

Thank you very much.

I have no other questions.

Mr. WAXMAN. Mr. Luken, any questions?

Mr. LUKEN. Well, just pursuing that on the second branch of your response as far as public health is concerned, public health officials and officers, there really isn't any alternative, any other available sources of providing the resources to meet the problems that the public health officials are dealing with, is there? You have mentioned two aspects of it. One, is their mission specific enough that we can handle it, that we can say that it is worthwhile and you mentioned in some cases it is and in others you are not sure.

But as to the second part as to are there any alternatives, you can't provide them and we don't know where else we could provide them except through existing public health programs, right?

Dr. RUHE. That is true. We have taken the position in the past that it was important to have graduate schools of public health receive institutional support for that reason. We have felt that this area is an area which has not been well supported in other ways. It is true that the States have not generally supported the schools within their own borders partly because these schools had goals and missions which seemed to go well beyond the State and were more national in scope than they were State in scope.

It is true that the graduate schools of public health have been in a sense a poor country cousin as far as being in the front row in getting primary support for their activities and we have felt that they did deserve that kind of support. I think it gets to be a very

hard question to answer when one comes down to the assembly of priorities in today's situation. That is the difficulty.

Mr. LUKEN. Doctor, I believe in your testimony that you haven't mentioned capitation grants for NHSC programs. I assume that the AMA is more or less resigned that there is going to be much reduced activity in those areas.

I am wondering if that resignation could exist, if you want to discuss this at all, and it is due to the inevitability because of the new administration and their programs or whether you feel we have really reached that point in time no matter who was in the White House or what kind of legislative goals we were operating under, that we have reached that point in time where NHSC and capitation grants are going to be out?

Dr. RUHE. Well, let me speak first to the capitation grants or what we would prefer to call general institutional grants for support of the medical schools. It continues to be our policy and we have so testified before this committee and Senate committees in the past that there should be some kind of general undifferentiated support for the medical schools to provide financial stability for them through good times and bad.

We do believe that it is true that the academic health of an institution depends upon its having some kind of a reasonably sound financial base. Medical education is a very expensive process. It is very expensive to start a school and it takes a long time to get it into motion and into action and into construction as you all know.

Over a period of time we have had a kind of a crisis situation always occurring it seems. Schools disappear and then there are shortages identified and then it is necessary to produce new schools in a great hurry and there is a crisis situation and then there is a major expansion.

Now it appears that many individuals believe and many agencies believe that we are approaching a level where we have enough physicians. We have not as an association agreed with that statement as yet but certainly the expectations for the future appear to be that there will be an adequate supply of physicians. So at that point it appears that most everybody loses interest in providing any permanent stability for the school, they feel that the immediate goal has been met and we have more doctors and therefore withdraw the support.

The problems of maintaining a sound academic base for a continued supply of physicians to meet the health care needs of the public is going to continue for the future even though it appears now that the supply of physicians could be adequate. But there are all kinds of things that could change that picture quickly. You know, an international incident of some sort could immediately increase the demands for physicians in a certain area.

So we have taken the position that some kind of basic institutional support is a sound principle. We still believe in that but I think we are resigned to the fact that in the present climate capitation is likely to disappear. We have not made a specific point of it in our testimony as the issue is currently under review.

As far as the National Health Service Corps is concerned, we have been in support of that program. We think that it is difficult

to predict what the impact of the people now in the pipeline will be for the future. There are a large number of persons, as you are aware, already in the system and it takes a while for them to come through and emerge on the other side and serve in the shortage areas and produce the impact that they are going to produce.

We have been somewhat concerned about the location of some of these individuals. We believe that for the future at least, they should be located exclusively in the group designated as one and two priority areas rather than in the three and four, based on a pretty clear identification of shortage areas.

We are now examining the continued need for new NHSC scholarships at this time to allow a better opportunity to evaluate the effect of the problem over the next few years and to see then at that time whether the anticipated adequacy of the physician supply comes into some better equilibrium as far as distribution is concerned.

There is some evidence that there is a filtering out of physicians from the centers now into less populated areas and this is true both for primary care and for secondary care physicians. It is going to take a while until we can assess the impact of that and then relate it to the value of the National Health Service Scholarship Program.

One of the attractive things about this program as far as the students are concerned is that it is an important part of student aid. But we think it is a mistake to maintain that system as the means of providing financial assistance for students because that really is not its primary purpose. If the need is student aid, then we ought to focus on student aid and deal with that problem.

Mr. LUKE. I think that is very helpful to us, Doctor.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Luken.

Mr. Benedict.

Mr. BENEDICT. Thank you, Mr. Chairman.

Good morning, Doctor. In your testimony there is a sentence: "The AMA is committed to seeing that financial resources are available to qualified aspiring health professionals." That is a laudable position. Can you tell me, please, what programs the AMA has in the way of scholarship funds or student aid programs or loan programs that your professionals institute to help aspiring and needy professionals?

Dr. RUHE. It is an ambitious statement and perhaps it should not have been stated in those strong terms. I must say that it can be seen as little presumptuous. We have for many years tried to provide not scholarship support but loan support for students. We have had our own guaranteed loan program in operation for many years. It is now in operation.

I am somewhat embarrassed to say we have had to discontinue granting new loans under that program because the amounts that we had guaranteed and the threat of being forced to supply the guarantee for defaulted loans got to the point where we could not maintain the financial stability of the program.

We also have a continuing program, and it still continues, of urging the membership and all physicians to support their own medical schools and the medical schools in the area in which they

are practicing; that is, to support the schools from which they graduated and the schools in the areas in which they are practicing.

We have cited it repeatedly and continue to cite it as a responsibility of the profession to assist in the providing of financial assistance to medical education as a whole and that a very important part of that is the financial support of students in the medical schools. So that is what the statement could have said had it been expanded.

We feel it is the responsibility of the profession and I guess by encouragement and exhortation and that kind of assistance through our constituent societies we have tried to promote that.

Mr. BLEHART. Let me just add that the loan program which was the AMA ERF program currently has guaranteed \$45 million in outstanding loans at an interest rate of 8 percent. The program was suspended last year because of the Carter administration's reserve requirement on all such loan programs which would have made the program very difficult to continue because it would have been impossible to forward that much in the way of reserves.

It has been a program in existence for 18 years and the plans are to continue the program once the market stabilizes. But with the interest rates as high as they are, as you understand, the banks are not willing to continue underwriting 8-percent loans and the AMA is in no position to extend loans and guarantee loans at the current market rate. So we are waiting to see what the situation is going to be when the market does stabilize.

Mr. BENEDICT. Thank you. I will be honest. It is important to me that your commitment to this goal goes beyond simply the expenditure of public money. That is the reason I asked you what your profession is doing particularly. I think that is important. We see so many people that come with their hand out but they won't make the effort themselves. I for one and my people are frankly tired of that.

Thank you, Mr. Chairman.

Dr. RUHE. We had our own loan program before the Federal program got started.

Mr. WAXMAN. We want to thank you very much for your testimony today. It has been very helpful to us.

We have next a panel on veterinary medicine, podiatry and pharmacy.

We have Dr. Donald A. Abt, associate dean of the School of Veterinary Medicine of the University of Pennsylvania; Richard Baerg, President of the American Association of Colleges of Podiatric Medicine; and John Schlegel, assistant executive director of the American Association of Colleges of Pharmacy who will be accompanied by Jack Bilby, a 5th-year student at the University of Maryland School of Pharmacy.

I would like to ask all of you to please come forward at this time.

We want to welcome each of you today to this hearing. We are going to ask you to summarize your statements in no more than 5 minutes. The complete text of your statement will certainly be made part of the record.

STATEMENTS OF DONALD A. ABT, D.V.M., ON BEHALF OF ASSOCIATION OF AMERICAN VETERINARY MEDICAL COLLEGES; RICHARD BAERG, PRESIDENT, AMERICAN ASSOCIATION OF COLLEGES OF PODIATRIC MEDICINE; JOHN F. SCHLEGEL, PHARM. D., M.S.ED., ASSISTANT EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY; AND JACK BILBY ON BEHALF OF AACP

Dr. ABT. Mr. Chairman and members of the subcommittee, my name is Dr. Donald Abt and I represent the Association of American Veterinary Medical Colleges.

We have a statement which has been provided for the record and I will summarize our major concerns.

We appreciate your continuing interest in health professions education as reflected in the introduction and consideration of H.R. 2004. We have serious problems confronting our schools and our students and H.R. 2004 provides some steps toward alleviation of some of those problems.

For many years it has appeared that the national health professions education policy has been based on the supply of physicians and the problems in medical education. While we can understand the reasons for that, we would point out that many health professions have problems which differ greatly from those of physicians, and the other health profession schools have problems which differ from the medical schools. We hope that these differences will be recognized and considered.

In our statement we have attempted to point out some of the unique contributions of the veterinary medical profession, the problems of its schools and the problems confronting veterinary medical students today.

We need Federal institutional support now as we have in the past 15 years. We are concerned that the diminishing federal financial support for educational institutions cannot be compensated for from other sources except to a limited extent from increased student tuition and fees. This we regret because our students are now encountering great difficulty in financing their education.

We sincerely hope that we do not have a national health professions education policy which permits only those who are very wealthy to seek careers in the health professions. Student financial aid programs are absolutely essential for veterinary medical students.

We are pleased to see that H.R. 2004 proposes to continue the health professions student loan program. Notions we hear regarding reducing student financial aid programs simply do not, in our opinion, recognize the realities of current costs of health professions education.

The health professions student loan program, the provisions for loan forgiveness for specified professional services and the guaranteed student loan program have been of major assistance to veterinary medical students. We believe that these programs must be continued and expanded especially in view of the diminished institutional support and the increasing costs of student living.

One of our major veterinary manpower shortage problems now and for the future is in the post-doctoral specialties, including veterinary pathology, toxicology, and laboratory animal medicine.

These are the specialties which are required for comparative medical research, livestock production efficiency improvement, pharmaceutical product development, and veterinary medical education.

A General Accounting Office study requested in 1977 by Chairman Waxman noted that one of the problems in the National Cancer Institute's carcinogenesis program was a shortage of toxicologists and veterinary pathologists. This is just one very significant example of the nature of this shortage.

Without new funding sources this problem will continue and become greater because new graduates with high debts to be repaid need appropriate stipends to continue education for a specialty and the schools and colleges must have money to provide the training programs.

We recommend that a new special project program be authorized to provide through grants and contracts the necessary funds to expand post-doctoral education in several veterinary specialties. We will be pleased to provide our recommendations for a specific amendment to H.R. 2004 for this purpose.

We appreciate this opportunity to express our views and present recommendations. I will be glad to try to answer any questions which you may have.

[Dr. Abt's prepared statement follows:]

STATEMENT
OF
DONALD A. ABT, D.V.M.
FOR THE
ASSOCIATION OF AMERICAN VETERINARY MEDICAL COLLEGES

Mr. Chairman and members of the Subcommittee, the Association of American Veterinary Medical Colleges appreciates this opportunity to express its views regarding H.R. 2004. I am Donald A. Abt, Associate Dean of the School of Veterinary Medicine at the University of Pennsylvania, and I speak today for the Association of American Veterinary Medical Colleges, which represents the twenty-five schools and colleges in the United States.

Last year we appeared before this subcommittee with recommendations which we thought were appropriate regarding federal sharing in the cost of health professions education and specifically veterinary medical education. Our problems of operating quality programs in veterinary medical education continue as do the problems of our students. Another year has passed and the sources of financial support for our programs and our students have become more uncertain while the costs continue to climb. Demands for veterinary services, escalating costs of educating veterinarians, and severe limitations on sources of income for veterinary medical schools have put these vital programs in jeopardy.

In the past few decades, startling changes have occurred in the veterinary medical profession. While the original and most obvious service -- the delivery of direct health care to animals and the relationship of that service to food supplies and the nation's economy -- remains a basic and vital function, it is but one part of a larger responsibility. Thousands of veterinarians work for governmental agencies at all levels, helping to implement regulations designed to assure that only safe, wholesome animal products are marketed for human consumption. Others are involved in public health matters such as the direct hazards to human health from transmissible animal diseases and the dangers arising from toxins and environmental pollutants. Comparative medicine, that area of study that deals with the interface between animal and human medicine,

demands the skills and attention of investigators trained in schools of veterinary medicine. If those on the front lines of veterinary medical activity are to have the knowledge and tools to perform effectively, research in the laboratories and in the field must be relentless, and it must be pursued by highly trained professionals.

Veterinary medicine is a biomedical science of such breadth that its members are now among those best equipped to deal effectively with the complex interrelationships among human beings, animals, and the environment. If society is to continue to benefit from advances in veterinary medicine, there must be no lapse in the quality of those trained to pursue it. Currently about 8,150 students are enrolled in twenty-five colleges and schools of veterinary medicine in the United States. About 1,950 new veterinarians will be graduated this year. Clearly, any significant reduction in the quality of training would impair a vital national resource. Nevertheless, several factors are threatening to do just that, foremost among them the financial squeeze.

The cost of veterinary medical education ranks among the highest in the health professions, far beyond the amount that can be recovered from tuition and other usual sources of college income. Twenty-two of the veterinary medical colleges are in state universities, and these states cannot be expected to continue to finance the major part of the nation's costs for veterinary medical education. Like schools devoted to training physicians, veterinary medical colleges maintain a high ratio of faculty to students, particularly in the clinical aspects of training; veterinary schools face high costs in recruiting and maintaining high quality faculties; they must provide expensive laboratories and equipment for teaching the full range of biomedical sciences; and they must provide those vital arenas of instruction, modern teaching hospitals.

Unlike their counterparts in human medicine, those responsible for training veterinarians must prepare their students to deal with complex health problems of not one but many species. They must do this without access to some major sources of income available to medical schools. Most significant for animal health care, there are no third-party payer systems available to owners of animals requiring medical care. This results in severely limiting the service income of veterinary medical teaching hospitals. Income in such hospitals rarely provides more than half the needed support.

With costs of veterinary medical education approaching \$20,000 per year per student it would be folly to presume that the students can carry the major part of the financial burden of their education. While physicians are often seen as able to command high incomes and therefore repay large educational debts, the situation for veterinarians is quite different. Starting salaries average about \$18,500.

The diminishing federal financial support of recent years and rapidly rising costs have increased the burden on the state governments and veterinary medical students. Current public concern over levels of state spending inhibits sufficient expansion of state appropriations for veterinary medical education. To attempt to close the income-cost gap by further limiting the enrollment of out-of-state students would be tempting but shortsighted. Because of the geographic locations of the institutions, many states would be underserved, and entire regions of the country would be shortchanged.

In most respects, we believe, the previous health manpower laws have been effective in achieving the national priorities in veterinary medical education. Capitation grants have provided funds which could be used to improve the quality of educational programs. The declining level of capitation grant funds in recent years has resulted in many losses which reflect

immediately on educational quality, and they include reduced purchases of library books and other autotutorial resources, reduced employment of technicians to aid the faculty, and, in some cases, reductions in faculty numbers. Recent federal policies have appeared to be based largely on perceptions of the needs for physicians and the support of medical education. The several health professions differ from medicine and from one another. We have pointed out some of the ways in which veterinary medicine is unique and how it benefits society today. We believe the decisions to phase out institutional support will continue to reduce the quality of education unless alternate sources of such funding are developed. The limited financial resources of the states make it improbable that many of them will be in a position to provide increased financing for veterinary medical education, which leaves the burden largely with the students, and student financial aid becomes even more important for the future.

We are pleased to see that H.R. 2004 proposes to continue with appropriate modifications the institutional financial distress grants. Without this source of funds in recent years the School of Veterinary Medicine at Tuskegee Institute could not have continued as an accredited veterinary medical college. That school serves a unique role in veterinary medical education and contributes through its distinguished faculty in many significant ways to the advancement of veterinary medicine. It must have this source of financial assistance until it can complete currently planned operational, managerial and financial reforms.

Continuation of the Health Professions Student Loan Program is extremely important to veterinary medical students since it provides a major source for them of moderate interest rate loans. We are pleased to see that H.R. 2004 proposes to extend the HPSL program through 1984, although we believe the

authorized appropriation levels are too low. Unless loans are available from this source, students will be forced to seek high interest rate Health Education Assistance Loans, which is an unsatisfactory alternative. New graduates with massive high interest rate loans to repay will be forced to select the highest income producing jobs. Economic factors will prevent them from taking jobs in which service may be more essential or continuing their education for service in currently undersupplied specialties. Notions we hear regarding reducing student financial aid programs simply do not, in our opinion, recognize the realities of current costs of health professions education. The Health Professions Student Loan program, with provisions for loan forgiveness for specified professional service, and the Guaranteed Student Loan program have been of major assistance to veterinary medical students. We believe that these programs must be continued and expanded, especially in view of the diminished institutional support and the increasing costs of student living.

Extension of the scholarships for students of exceptional financial need is a vital action to help assure that students from low income backgrounds may prepare for a health profession. While few veterinary students have had the benefit of such scholarships, we believe the program will be even more essential in the future, and we fully support its extension and the provision to extend such scholarships through the second year of professional education.

We hope that the Congress will continue to recognize the increasing necessity of federal financial aid for health professions students. In view of the diminishing institutional support, adequate resources for student assistance must be available or the health professions will soon be restricted to only the very wealthy.

Veterinarians trained as specialists in biomedical research, livestock production research, pharmaceutical product development, and veterinary

medical education are scarce. The numbers are too limited now for the existing demands, and economic pressures on institutions and students indicate that this situation will continue unless action is taken now to provide incentives and resources for post-doctoral education. Veterinary pathologists and toxicologists and laboratory animal veterinarians are currently needed in significantly greater numbers than are available.

The General Accounting Office reported to Representative Waxman on March 30, 1979, that it had found in its review of the National Cancer Institute's carcinogenesis program that a major factor causing failures in the program was " . . . a shortage of toxicologists and veterinary pathologists" This is only one illustration of an extensive problem which is not improving. The National Academy of Sciences is currently studying this matter with the intent of documenting the nature of these health manpower supply problems. Large debts to be repaid after graduation from veterinary medical college discourage or prohibit new graduates from continuing their education unless appropriate stipends are available. The veterinary medical colleges cannot provide the post-doctoral education opportunities without additional funding for that purpose. We recommend that a new special project program be authorized to provide through grants or contracts the necessary funds to expand post-doctoral education in several veterinary medical specialties. We will be pleased to provide our recommendations for a specific amendment to H.R. 2004 for this purpose.

Mr. WAXMAN. Thank you very much. We appreciate that statement.

Dr. Baerg, why don't we hear from you next.

STATEMENT OF RICHARD BAERG

Dr. BAERG. Mr. Chairman and members of the committee, I am Dr. Richard Baerg, president of the American Association of Colleges of Podiatric Medicine. The Association represents the five independent colleges of podiatric medicine which educates this Nation's entire supply of podiatrists and I am pleased to be here today to provide testimony on behalf of H.R. 2004.

The challenges facing podiatry in the 1980's are unique among the health professions. The 1980 Report to the President and Congress on the Status of Health Professions Personnel identifies podiatric medicine as having a greater manpower shortage and maldistribution problem than does any other medical care discipline.

The Federal Government has been mindful of podiatry's dilemma and has in a number of ways extended assistance. The Department of Health and Human Services responding to a Congressional directive has just completed an in-depth study of the need for and feasibility of a new college of podiatric medicine in the Midwest.

Similarly, the Department has let a contract jointly to the American Association of Colleges of Podiatric Medicine to conduct a study of alternative methods of educating doctors of podiatric medicine with a view toward expansion of the number trained.

With the impetus of Federal aid the five colleges of podiatric medicine have dramatically increased enrollment since the midsixties. In 1966 there were 700 podiatric medical students enrolled. Today there are over 2,500. In 1966 the colleges awarded degrees to 135 individuals and in 1980 to 577. Additionally, each college now has newly constructed or completely renovated physical plants. Despite this movement much remains to be done.

The Department of Health and Human Services has projected a need to double by 1990 the nationwide podiatric manpower supply. At current graduation rates, however, there is projected a 30-percent shortfall of practicing podiatrists in this country by 1990.

With each of our colleges currently educating maximum numbers of podiatrists there is no chance of eliminating this shortfall without a Federal commitment to assist in expanding the operations of these institutions.

We propose that the committee institute a special project authority within the Health Professions Education Assistance Act designed to alleviate both the shortage and maldistribution problems in podiatry through regional efforts by the colleges of podiatric medicine.

Under the proposal colleges would receive Federal funds to institute an intensive effort to recruit students from underserved areas from across the country. In addition, the colleges would guarantee that the students would receive their clinical training in underserved areas.

We believe that this type of special project would have an immediate and positive impact on both the shortage and maldistribution problems in podiatry. The program would provide our colleges with needed incentives and resources for increasing enrollment.

Further, by focusing on recruitment and clinical training efforts in underserved areas of which the Department of Health and Human Services has identified 1,400 nationwide for podiatry, we would be more certain of attracting significant numbers of students with an orientation toward the eventual practice in such areas.

STUDENT ASSISTANCE

Student assistance programs are critically important to students of podiatric medicine. According to the 1980 Report to the President and Congress on the Status of Health Professions Personnel, "Students of podiatric medicine reported higher average expenses than students of any other discipline."

The current cost of podiatric medical education is more than \$14,000 annually per student. Students of podiatric medicine bear half of the cost of their professional education, a far higher percentage than in any other profession. It is not surprising that students of podiatric medicine are far more involved in the high-interest health education assistance loan (HEAL) program than are students of any other profession.

We are gratified to note the support in H.R. 2004 for the National Health Service Corps and its scholarship program. Students of podiatric medicine have only recently begun participating in the National Health Service Corps scholarship program. With proper recruitment and orientation efforts we believe that this program will be successful in providing quality health care in underserved areas.

We are very excited about participating in this program and we request that the committee legislatively earmark a certain percentage of scholarships for podiatry based on relative shortages vis-a-vis the other primary care medical professions.

We also support the emphasis in this bill on facilitating the entry of minority students into the health professions. Efforts on the part of podiatry to recruit and retain students from under-represented groups have met with only limited success.

Representation of minorities in podiatric medical schools increased from less than 1 percent at the beginning of the seventies to 9 percent today. Despite some gains, much more needs to be done in this area and we welcome the resources to accomplish our goals of full and fair representation of all groups in podiatry.

We support Chairman Waxman's proposal to extend the student loan program and suggest that funding be as full as possible for saving dollars at this level will cost the system far more when high education loans become due a few years from now.

Many of the concerns I have voiced here were echoed recently by the National Advisory Council on Health Professions Education. In a resolution, a copy of which I have submitted for the hearing record, the National Advisory Council pointed to the critical manpower shortages in podiatric medicine. The council urged that the Federal Government provide full professional and resource support to podiatry in its efforts to increase the supply of doctors of podiatric medicine.

This concludes my prepared remarks and I will be happy to answer questions of whatever you may have.

[The resolution referred to follows:]

Resolution on Podiatric Medical Education
(adopted by the National Advisory Council
on Health Professions Education 1/29/80)

WHEREAS, The Bureau of Health Manpower's 1978 Report to the President and Congress on the Status of Health Professions Education points out that the number of podiatrists in this country are currently inadequate to meet national health care needs, and

WHEREAS, because podiatry is moving toward an expanded function role in the areas of health promotion and disease prevention, the future needs for podiatrists take on an added dimension of concern, and

WHEREAS, statistical data contained in the above-mentioned Bureau of Health Manpower report projects a need for 24,000 footcare practitioners by 1990 while less than 9,000 are now available, and

WHEREAS, the five schools of podiatric medicine are now operating at full capacity and certain regions of the country including the South have no schools of podiatric medicine, and

WHEREAS, geographic maldistribution of podiatrists is more acute than in any other health profession,

THEREFORE, BE IT RESOLVED, that the Bureau of Health Manpower and its parent agency, the Health Resources Administration are urged to provide full professional and resource support to podiatry in its efforts to increase the number of graduates; to continue the provision of incentives to assure the matriculation of additional numbers of currently underrepresented population groups; continue the provision of incentives, especially by means of the National Health Service Corps scholarship program, to assure the placement of podiatrists in underserved areas; to participate in the continuing assessment of the functions performed by the various members of the health care team in a variety of urban and rural settings; to provide new incentives to stimulate the integration of new podiatric medical education programs into existing medical schools or health science educational programs; to encourage podiatric and interdisciplinary postdoctoral training, including increasing the number of residencies and encouraging participation of podiatrists in Area Health Education Centers and other continuing education programs; to continue to provide support to existing schools of podiatric medicine with a view toward educating greater numbers of podiatrists; and to provide regular reports to the Council, the Surgeon General, and the Congress regarding progress in reaching these important podiatric manpower goals.

Mr. WAXMAN. Thank you very much.
Dr. Schlegel.

STATEMENT OF JOHN SCHLEGEL, PHARM. D., M.S.ED.

Dr. SCHLEGEL. Good morning, Mr. Chairman and members of the committee.

On behalf of the Nation's 1,972 colleges of pharmacy, thank you for the opportunity to present our views on Federal health professions assistance. We appreciate and support your efforts to have the Congress take action on H.R. 2004.

In respect for the committee's time we will only speak to broad issues and rely on written materials being supplied for the record to give more background. Also, my colleagues and I are pleased to respond to questions.

As we have previously stated to this subcommittee, the loss of Federal institutional support will have great consequences for pharmacy education. We risk the loss of substantial numbers of new clinically trained members of our faculties as well as further inflation of tuition.

In view of the fiscal pressures facing this Congress and all citizens the written record of my remarks includes some examples of the life and cost savings realized as a result of the past Federal pharmacy partnership in training new practitioners.

It is well documented that appropriately trained pharmacists can and do save lives, reduce drug misadventures, and help the public avoid more costly types of care. We hope that you will consider an investment in pharmacy education a prudent one and one the Nation must continue to make.

In the spirit of cooperation to meet society's changing needs, we once again recommend to you authorization of a dedicated pool of funds to support special programs for colleges of pharmacy to prepare graduates to respond to national health priorities.

This proposal embraces the concept of seed money to facilitate implementation of new programs. It is not a proposal for long-term support of established programs. Although special project funds would not directly benefit all schools, such funds do stimulate excellence and innovation through nationwide competition. They can also be awarded based on regional and State health needs and objectives.

We urge the addition of support for clinical pharmacy residency programs. Currently postgraduate programs in pharmacy are being accredited in hospitals and community facilities in important areas such as ambulatory and primary care, mental health, geriatrics, toxicology and poison control, pharmacokinetics, oncology, and pediatrics. These residencies are oversubscribed. More of them need to be developed to strengthen the pharmacist's ability to promote rational drug use as active participants of the health care team. These residency training programs also allow pharmacists and other health providers to negotiate appropriate service relationships that maximize care and minimize costs to patients.

Because our organization believes strongly that students are the most vital of national resources, a student of pharmacy has joined me this morning to discuss further the needs of students.

[Testimony resumes on p. 402.]

[Dr. Schlegel's prepared statement and attachments follow:]

STATEMENT BY THE AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY
ON H.R. 2004

US HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY & COMMERCE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

March 12, 1981

Presented by John F. Schlegel, Pharm.D., M.S.Ed., AACP Assistant Executive Director

Mr. Chairman:

On behalf of the nation's 72 colleges of pharmacy, thank you for the opportunity to present our views on federal health professions assistance, specifically H.R. 2004. In respect for the committee's time, we'll only speak to broad issues and rely on written materials being supplied for the record to give more background. Also, my colleague and I are pleased to respond to questions. As we have previously stated to this subcommittee, the loss of federal institutional support will have grave consequences for pharmacy education - we risk the loss of substantial numbers of the new clinically trained members of our faculties as well as further inflation of tuitions. In view of the fiscal pressures facing this Congress, and all citizens, the written record of my remarks includes some examples of the life and cost savings realized as a result of the past federal/pharmacy partnership in training new practitioners. It is well documented that appropriately trained pharmacists can and do save lives, reduce drug misadventures, and help the public avoid more costly types of care. We hope that you will consider an investment in pharmacy education a prudent one -- one the nation must continue to make.

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facilities in important areas such as ambulatory and primary care, mental health, geriatrics, toxicology and poison control, pharmacokinetics, oncology and pediatrics. These residencies are over subscribed. More of them must be developed to strengthen pharmacists' ability to promote rational drug use as active participants of the health care team. These residency training programs also allow pharmacists and other providers to negotiate appropriate service relationship that maximize care and minimize costs to patients.

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ON H.R. 2004

US HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY & COMMERCE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

March 12, 1981

Presented by Jack Bilby, Fifth Year Pharmacy Student, University of Maryland,
School of Pharmacy.

Mr. Chairman:

My name is Jack Bilby. I am a fifth year pharmacy student at the University of Maryland School of Pharmacy.

As a student who has required federally supported financial assistance in the forms of a Basic Education Opportunity grant, Guaranteed Student Loan and Health Professions Student Loan, I would like to address the committee on the subject of student aid.

Students and their families are very concerned about how high the cost of education can go before we can no longer afford to be educated, particularly in view of the reductions being considered in federal student aid programs. My tuition, even at a state school, has been increasing steadily. Private pharmacy school tuitions have increased even more markedly. We realize that in comparison to other health professions student tuition, pharmacy tuition is relatively modest. But, just as pharmacy tuition is well below that of medical schools, the expected annual income of a pharmacist is well below that of a medical doctor. At the beginning of our careers, my classmates and I can expect an average salary of about \$20,000. At today's rates, our salaries are not likely to exceed \$30,000 at their peak. For this reason, pharmacy students, like myself, are reluctant to incur large long-term debts in financing our education.

We are most appreciative of the efforts of this subcommittee to continue the existing health professions student assistance programs. The changes in these programs proposed by H.R. 2004 seem, for the most part, positive and fair. On behalf of students who will follow me into pharmacy, I do request that the subcommittee consider the following:

First, identifying a portion of funds to be authorized specifically for pharmacy students under the Exceptional Financial Need Scholarship Program;

Second, clarifying that pharmacy students can have HEAL interest payments

deferred while those in approved residency programs and post-graduate programs and

Thirdly, encouraging the participation of pharmacists in the National Health Service Corps. Because pharmacists are now the best distributed and most accessible health professional, they have not been an integral part of the Corps. However, even though there are few absolute pharmacist shortage areas, there is a need to increase the number of pharmacists practicing expanded clinical roles in rural and other underserved areas.

Mr. Chairman, thank you for the opportunity of speaking to the subcommittee. It has been an honor and a unique learning experience for me.

PRIORITIES OF PHARMACEUTICAL EDUCATION IN RESPONSE TO
NATIONAL HEALTH NEEDS*

Introduction

Our country's most recent "Forward Plan for Health" has identified cost containment, primary care and access to services as public policy priorities in the financing and delivery of health care. The American Association of Colleges of Pharmacy, a non-profit educational society representing the 72 accredited colleges of pharmacy in the United States, concurs that these priorities require immediate attention and believes they should be addressed through the cooperative efforts of health-care providers, voluntary associations, educational institutions and government. At the same time, we urge a sustained effort and commitment to assure that these national health priorities are transformed into permanent characteristics of an ongoing public health policy and health-care delivery system. The economic viability of our nation and our citizens' right to health care demand no less.

Pharmacy, as an integral and vital component of health care, has made steady progress in containing health-care costs, improving primary care and assuring better access to services by improving the ways drugs are prescribed, dispensed, administered and used. Over the long term, the extent to which these contributions can be maintained and enhanced to their full potential depends almost exclusively on the content and quality of pharmaceutical education.

The dramatic transition in professional academic programs in pharmacy toward direct patient care in a clinical environment has significantly increased the cost of pharmaceutical education. In recent years, this increased cost has been offset by federal capitation funding requiring clinical orientation in the pharmacy curriculum. It is the strong conviction of the American Association of Colleges of Pharmacy that federal financing of pharmaceutical education must be continued in some form to assure that future pharmacists accelerate the profession's contributions in addressing national health priorities. Recognizing that continued federal financing must be justified through evaluative research on the impact of pharmacy practice as it relates to national health priorities, the Association has encouraged its individual members and member institutions to design and implement controlled field studies, including cost-benefit and cost-effectiveness studies, in an attempt to document pertinent pharmacy practice achievements.

The selected research reports and financing priorities in the following sections are cited with the additional recognition that continued federal financing of pharmaceutical education must be based on objective data relating to national health needs rather than on the individual needs of academic institutions or geographic areas.

* Revised January 28, 1981

Pharmacy Practice Achievements

Pharmacy practice achievements as they relate specifically to cost containment, primary care and access to health-care services, involve pharmacists' expanded roles in ambulatory, acute and extended care.

Among the best examples of the cost effectiveness of the pharmacist in these roles are pharmacist-conducted training programs that teach patients to self-administer certain parenteral medications at home. Selected patients at the Ohio State University Hospitals and others are trained to self-administer calcitonin, injectable analgesics and steroids, antihemophilic factor, cytarabine and parenteral nutrients, thus minimizing the cost of outpatient clinic, physician or home nurse visits. (1,2) Financial data on these programs indicate that savings far outweigh costs. For one patient alone, a hemophiliac receiving Factor VIII, savings were more than \$20,000 in the first year. (3) A follow-up report based on the records of 35 patients participating in the programs for two years estimates that about \$322 in hospital costs were saved for every dollar charged by the pharmacy; the total savings were estimated at more than \$833,000. (4) The pharmacists' professional services under these programs are reimbursed by Blue Cross; approval of such payment by a third party is viewed as a major step in recognizing the cost effectiveness of the pharmacist's clinical role.

Other examples of reimbursement for clinical pharmacy services include programs whereby third parties reimburse, on the basis of documented costs, for growth hormone home instruction and patient consultations and visits, (5) and for pharmacokinetic consultations by pharmacists. (5,6)

Several published reports indicate that pharmacists' therapy management or monitoring of patients with chronic diseases such as hypertension or diabetes may result in cost savings through improved treatment outcomes and better utilization of health-care personnel. One report described the effect of patient-oriented pharmaceutical services on treatment outcomes of diabetic patients who were randomly assigned to study and control groups. (7) Patients whose therapy was monitored and who were counseled by a pharmacist showed improved symptomatology, required significantly fewer changes in therapeutic regimen, and had a lower incidence of hospital admissions and physician contacts as compared to patients in a control group. In another study, patients with essential hypertension revealed significant improvement in knowledge of the disease, compliance with prescribed therapy, maintenance of blood pressure within the normal range and the requirement of physician follow-up when clinical services were provided by a pharmacist. (8) A study funded by the National Center for Health Services Research and conducted at a Public Health Service Indian hospital determined the effectiveness of a pharmacist in the management of patients on long-term drug therapy. Working under detailed chronic care protocols and defined health parameters for specific

chronic diseases, more efficient utilization of both pharmacists and physicians was achieved without sacrificing quality of care. (9) Although the three studies mentioned above did not specifically address cost savings, they suggest substantial savings through a reduction in hospitalization or physician visits.

In a cost-benefit study conducted in an outpatient clinic of a large medical center, the average prescription cost for patients who received only traditional pharmacy dispensing services was more than 2.5 times that for patients whose therapy was monitored by a pharmacist. (10) The difference in cost was attributed, in part, to the use of patient medication profiles, the selection of less expensive drugs when possible and the elimination of drug duplications through coordination of therapy prescribed by more than one physician.

A report of a study in nineteen hospitals indicated that clinical pharmacy services combined with a unit-dose medication system could reduce overall costs by \$.79 to \$1.25 per patient day. (11) This finding assumes added significance when considering that the American public is hospitalized in short-term general hospitals for approximately 275 million inpatient days per year.

Participation by pharmacists in medical rounds in a 250-bed pediatric hospital resulted in cost savings of \$.54 per patient day solely through elimination of medication waste due to late drug order changes. (12) Assuming 90 percent occupancy in this hospital, the total yearly savings would be nearly \$45,000. In another controlled study conducted in a pediatric hospital, monitoring of total parenteral nutrition therapy by pharmacists significantly reduced patient costs and improved response to therapy. (13) Another report indicated that clinical pharmacy services were responsible for reducing the hospital stay, by one day, of 20 percent of 130 internal medicine patients. (14) By extrapolating the net cost of the pharmacists' services to a yearly basis, the savings for just the two internal medicine wards would be more than \$20,000. A pharmacy program of discharge medication interviews in another university hospital resulted in substantial dollar savings for patients and was deemed to be cost beneficial. (15)

A study carried out in four skilled nursing facilities, one of which served as a control, demonstrated that clinical pharmacy services resulted in estimated savings of \$80,000 per year for 300 patients (\$.73 per patient day) through reduction in the use of inappropriate or unnecessary drugs and prevention of adverse drug reactions. (16) Clinical pharmacy services provided to 25 Medicaid patients in a skilled nursing facility in Washington state resulted in savings of about \$6 per patient month through reduction of unnecessary drug use. Projected to all such facilities in the state, the net savings to the Medicaid program would be \$747,000 per year. (17) Another study of comprehensive pharmacy services in three long term care facilities demonstrated a 30 percent reduction,

or \$9 per patient per month, in average medication charges. (18) Finally, drug regimen reviews performed by pharmacists in six skilled nursing facilities and one institution for the mentally retarded resulted in a reduction of 0.9 to 2.44 prescription orders per patient per month. Extrapolation of the dollar savings to all Medicare and Medicaid skilled nursing facilities in the country would yield net savings of \$3.2 million to \$37.2 million per year. (19) Several reports of drug-related problems in nursing home patients, and of the positive effects of pharmacist intervention to alleviate these problems, have resulted in a call for expanded pharmacist involvement in drug therapy review in extended care facilities. (20)

These selected reports are cited to demonstrate that direct patient care activities of the pharmacist--activities which are emphasized in contemporary pharmaceutical education--have had and can continue to have a decided impact on national health priorities. We have not attempted to demonstrate how more traditional, yet still important, activities of the pharmacist in drug procurement and distribution (e.g., the hospital formulary system and unit-dose medications systems) can affect cost savings in health care. Cost savings and other benefits of drug product selection by the pharmacist, as well as of unit-dose drug distribution systems, have been well documented elsewhere.

The Federal/College of Pharmacy Partnership

Pharmacy education has rapidly evolved over the past decade and now stands together with other health professions schools in preparing students to deliver clinically oriented, personal health care services. The American Association of Colleges of Pharmacy believes the high costs of clinically oriented academic programs in pharmacy, coupled with evidence of the public interest served through the cost effectiveness of clinically oriented services provided by pharmacy practitioners, call for a continued, broad-range federal partnership in the financing of pharmaceutical education and research. Accordingly, it is recommended that federal support should be in the form of institutional funding to advance policy priorities in health care, student assistance, and academic residencies.

Institutional Funding - The Association urges continuation of institutional funding of colleges of pharmacy to maintain clinical pharmacy education developed under the incentive of prior and current health manpower legislation. We believe that it is in the public's interest to use this funding mechanism to stimulate programs in other national priority areas such as primary care, geriatric care, drug abuse/misuse, and health economics. Since incentives to increase student enrollments are no longer necessary, schools should not be penalized for failing to reach a fixed minimum enrollment level. We believe individual state and regional manpower needs, population changes, and local priorities are the most appropriate determinants of enrollment levels. The Association further recommends that consideration be given to providing incentives to increase the number of underrepresented minorities in the profession.

The Association also recommends direct federal support of individual institutions on a competitive project basis. Specifically, it is suggested that institutional financing be enhanced by a dedicated pool of funds to be used for development, support, and evaluation of institutional projects on a competitive basis. These grants would support important experimental and exploratory programs directed toward emerging national priorities.

Since most schools and colleges of pharmacy have adequate physical facilities, and since substantial portions of their academic programs are now offered in patient-care environments, the Association is requesting consideration of federal financing of construction only as it may relate to (1) construction or renovation of patient-care facilities in health science centers when such practice facilities are integrated with educational programs in clinical pharmacy, and (2) clinical pharmacy outreach programs in other institutional and community settings.

Student Assistance - In addition to direct institutional support as a mechanism to controlling student costs, the Association recommends programs for direct student assistance. It should be noted that a pharmacist's salary throughout his or her entire career remains modest; consequently, it is inappropriate to expect pharmacy students to pay high tuitions or to incur heavy debts. It is recommended that such student assistance include subsidized student loans, health professions scholarships, and aid for especially needy students.

Residencies - The preceding discussion has identified numerous examples where advanced level pharmacy practitioners have made valuable contributions to health care. Advanced level training in pharmacy is being efficiently and effectively provided, albeit in limited numbers, through the mechanism of clinical training residencies. The Association therefore recommends federal support for academic residencies to satisfy the increasing demand for more highly trained pharmacists in administrative, technical and clinical specialties.

Summary

The American Association of Colleges of Pharmacy recognizes and endorses the concept that federal financing of pharmaceutical education must be based on documented public needs. Evaluative research to date indicates that direct patient-care activities of pharmacists--activities which reflect the direction of contemporary pharmaceutical education--have had a beneficial impact on patient-care with corresponding reduction in health-care costs. In order to maintain these cost-effective programs in pharmacy education it is necessary to continue the federal/college partnership in financing pharmaceutical education.

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THE PHARMACY/FEDERAL PARTNERSHIP: DIRECTIONS FOR THE EIGHTIES*

INTRODUCTION: THE 1970s, A TIME OF CHANGE FOR PHARMACY EDUCATION AND PRACTICE

The Problems We Faced and Face

American is a nation on drugs--and not necessarily illicit ones. During the late 1970s, physicians and other practitioners wrote more than 1.5 billion prescriptions annually for their patients; three out of four doctor/patient encounters now result in at least one prescription. That's seven prescriptions for every man, woman and child in the country.[†] That figure does not include the profusion of drugs employed to treat the hospitalized patient. Furthermore, as recent hearings held by the House and Senate Committees on Aging have highlighted, our elderly population--particularly those in nursing homes--are given an extraordinary number_{2,5} of drugs; many receive more than eight different drugs daily.

For at least a decade, it has been well known that there are major problems associated with the utilization of many prescription drugs. These include adverse or untoward reactions, interactions among drugs which can either enhance or negate the effectiveness of a therapeutic regimen, and disease induced modification of drug response. Furthermore, the plethora of available drugs confuses many physicians and sometimes leads to less than effective therapy. Over utilization or inappropriate drug selection increases the cost of the total medication bill. Finally, patients frequently do not comply with their physician's directions and, hence, unwittingly harm themselves through incorrect use of their medicines. All of these problems are exacerbated by the high degree of drug consumption by our society and result in major, unnecessary costs.

Emergence of a New Pharmacist

In response to these startling facts, pharmacy education and practice underwent enormous change in the 1970s. A new pharmacist has emerged. This new pharmacist is not just a dispenser of prescriptions but also a direct provider of drug-related primary health care.

*Presentation made by Donald L. Sorby, Ph.D., Dean, School of Pharmacy, University of Missouri-Kansas City and President of the American Association of Colleges of Pharmacy at Council of Deans Legislative Breakfast Meeting, February 24, 1981.

†Questions or comments may be addressed to the author or to Ms. Barbara Rich, Director of the Office of Public Information, American Association of Colleges of Pharmacy, 4630 Montgomery Avenue, Suite 201, Bethesda, Maryland 20014.

In our hospitals, these new pharmacists have left the isolation of the pharmacy and have taken their knowledge of drugs to the bedside and ambulatory clinics where they can directly counsel both patients and other health professionals in the appropriate use of medications. They have established programs to monitor patients for early development of harmful side effects. New distribution systems have been designed to reduce drug administration errors and prevent inadvertent prescribing of incompatible drugs. Pharmacokinetic laboratories and computers assure correct dosing regimens for patients and drug utilization review programs have been developed to combat rising drug costs. Given that drug reactions are believed to cost about \$3 billion per year in extended hospital stays and that as many as 30% of hospitalized patients have drug reactions, pharmacists are making a step in the right direction.

In our nursing homes, pharmacist consultants now review each resident's drug therapy plan on a monthly basis to prevent unnecessary drug use as well as to avoid adverse drug reactions and interactions. The net savings in Medicare and Medicaid program funds, as a result of pharmacists' drug utilization review, has been estimated to range from a minimum of \$3.5 million to a possible maximum of \$40 million per year.⁵

In our communities the new pharmacist is not satisfied with counting pills and labeling prescriptions but seeks to give consumers the information they need to use drugs effectively and safely. Pharmacists are increasingly using patient medication profiles so that they may monitor individual drug programs for potential problems such as interacting drugs and non-compliance by patients. The movement of pharmacy in our communities toward a consumer counselling and education focus is certainly not complete but a good start has been made.

There remains a great deal to be done in fostering acceptance and practice of the expanded role of pharmacists. Evaluative research studies that document the effectiveness of pharmacists in addressing the socially important problems in drug utilization encourage the profession to continue efforts in this direction. I hope you will read our publication, Pharmacy Education; Responding to the Nation's Health Care Needs, which we have supplied to each of you this morning. It further describes our new pharmacist.

Response of Pharmacy Education and Research to Challenges of the 1970s

The ability of pharmacists to move into new roles of benefit to society was foreseen by the nation's 72 colleges of pharmacy. In fact, it was through their efforts to develop clinical practice models and their research and demonstration projects in the 1970s, that our schools pioneered the development of the "new pharmacist" needed to effectively address drug use problems of our society.

During the '70s, pharmacy schools adapted and improved their educational programs to emphasize the patient care--or clinical--component. While the first two pre-professional years of the traditional five-year baccalaureate program are still devoted to basic sciences, social science and humanities, the last three academic years have changed dramatically. Biological science and therapeutics instruction has been strengthened. Pharmacy students are now provided in-patient and out-patient clinical clerkship experiences which include interaction with physicians and other health professionals. Communication skills are taught and developed over this period. Students are trained to analyze drug therapy in the context of patient problems and to directly counsel patients and other members of the health care team. Highly motivated students can opt for the six-year doctoral program--the Pharm.D.--which provides more in-depth clinical training and prepares the graduates for advanced-level practice in patient-oriented roles.

Likewise, basic and applied research conducted by pharmacy school faculty has attempted to keep pace with the drug-taking characteristics and needs of the public. Some pharmaceutical scientists are exploring the nature of the pharmacokinetic performance of drugs in the human body and what this suggests in terms of new dosage forms or dosing methods. Others are developing new drugs which have improved effectiveness with lower risk of adverse reactions. Many of our schools have active toxicology research programs. A host of other important topics are also being investigated in our schools.

The Federal Role in the 1970s

These changes would have been extremely difficult, if not impossible, without the support and reinforcement of U.S. Congress and Federal government. During the last ten years, the nation's pharmacy schools have received over \$220 million from the HHS Bureau of Health Professions to further their educational missions. These monies have been used to support special projects that develop new educational strategies and professional role models, to alleviate financial distress, to augment student aid, to construct facilities and to provide institutional support in the form of capititation grants. Research support provided via the National Institutes of Health and other Federal agencies, although seldom sufficient in amount, has been invaluable to our research effort.

The Pharmacy/Federal partnership was indeed strong and productive during the 1970s. The new pharmacist, although conceived by the profession in response to societal need, could not have been created as quickly or effectively without Congressional incentives and Federal dollars. The relatively modest investment Congress made on behalf of the nation has, as I have described, provided a significant return to society.

THE 1980s; A TIME OF OPPORTUNITY

However, all of the drug-use and health information gaps have not been plugged. The 1980s present challenges continuing from the 1970s as well as new opportunities.

Emerging New Health Care Maintenance Needs of Society

Consumers are increasingly motivated by the desire to stay well, to care for themselves when they are not and to judiciously seek appropriate care only when necessary and then at the best price. Such consumers, acting on the incentive to save money, will strive to be better informed about their health. On the average, each American has 20 or more direct professional contacts with a pharmacist each year and the average pharmacy is open 65 hours per week. Pharmacists are clearly the most accessible of all health professionals. Being the most visible and accessible of health professionals, the pharmacist has the perfect opportunity to provide the public with information on a wide variety of health topics but, most specifically, on a disease prevention and health promotion. This role could easily extend beyond that of self care and expert drug counselling to that of being a general health care system interpreter. In this respect, the pharmacist can act as a liaison between patients and systems and assist them in using available services to best advantage.

Not only is the neighborhood pharmacy accessible to the general public, but the pharmacist is also easily available to the homebound. The rapidly growing elderly population could especially benefit from a pharmacist's assistance in their struggle to remain independent and at home in their chosen communities.

Primary Care Needs of the Underserved

As a national resource, schools of pharmacy can serve as change agents preparing pharmacists to meet primary care needs of the underserved as has been demonstrated by pharmacists in the U.S. Indian Health Service. Pharmacists can, and should, be called upon to provide a broader range of health services to the general community, especially in rural areas and the inner city.

Needs of Our Aging Population

The 1980s will see a dramatic rise in the percentage of elderly Americans in our population. Since the elderly are major consumers of drugs, this will put an added load on all health professionals to see that drugs are used properly and safely. For pharmacists, this will require not only an understanding of those unique features of drug effects in the elderly, but they must also be aware of the psychological and sociological factors which influence the behavior of such persons.

Pharmacy education is concerned about meeting the needs of the elderly population in every care setting. In fact, we view preparing our students for service to the aging population as, perhaps, the most significant challenge of this decade.

Cost Containment

Cost containment of all health care services will be a major challenge in the 1980s as services are extended to more Americans and as economic pressures increase. Pharmacists have already demonstrated they can fill an effective role in cost containment programs and they will continue to represent a major resource to the health care system in this respect.

New Research Initiatives

A number of new research initiatives should appear during the 1980s. Among these are studies on toxicology of chemicals and environmental toxins, development of new forms of drug administration, genetic engineering to produce new therapeutic agents, development of agents which suppress the activity of chemical carcinogens and mutagens and synthesis of improved medicinal agents. Research is also needed to determine methods to improve cost-effective drug utilization.

The challenges facing us in the 80s may be summarized as follows: we must be ready to meet the needs of a rapidly growing aging population as well as the emerging health promotion and maintenance needs of society as a whole. We must continue to find solutions to the problems associated with bringing primary care to underserved areas. We must pursue new research initiatives to help us answer these needs and improve the health status of all our citizens. And, if that isn't enough, we must find ways to do all of these things in ways that are economically feasible and cost-effective in themselves!

Colleges of pharmacy are prepared to be innovative and proactive in further developing the role of the new pharmacist to meet the challenges of the 1980s. We recognize that educational programs and research initiatives must continue to evolve. In order to maintain our momentum, however, a number of obstacles need to be overcome.

PROBLEMS OF OUR PHARMACY COLLEGES IN MEETING THE OPPORTUNITIES OF THE 1980s

Declining Federal Support for Health Professions Schools

There have been Congressional voices, growing ever louder over these last several years, that Federal participation in financing health professions education should be abandoned, drastically reduced, or otherwise markedly changed. Our state governments have not been eager to respond to our financial plight in the face of losing Federal support. Even those states that have

appropriated funds to benefit pharmacy schools, are now hard put to maintain these commitments. Furthermore, our private colleges are faced with the necessity of large tuition increases and must attempt to generate additional donations from the private sector in a time of economic recession. Coping with the uncertainties of both Federal and State support over the last several years has often acted to the detriment of our educational programs. Resolution of our financing picture is the most pressing problem of all our schools--public and private. We will continue to suffer until stable financing is achieved.

Pharmacy Student Support

Along with the possibility of losing Federal assistance, the difficulty of obtaining increased revenue from students through higher levels of tuition complicates our financial dilemma. Pharmacy schools have begun to see some decline in applications and the continued reduction in the college-age population promises potential enrollment problems. Pharmacy is in close competition with the other health professions for the same talented students. However, pharmacy cannot recruit students for our rigorous academic program on the same basis as most other health professions, for the annual income of our graduates can expect is far between that of medical or dental graduates. Although the average varies in different parts of the country, the pharmacist can only anticipate yearly earnings of \$20,000. Therefore, our tuitions must remain realistic. Even at current tuition levels, our students rely heavily on financial aid programs. The families of pharmacy students have the lowest median incomes of all health professions student families, except perhaps for nursing. These families cannot be expected to incur significant debts in support of their children. Recent reductions of student financial aid programs have hit hard among our students, especially the minorities and economically disadvantaged.

Problems of the Profession; A Need to Re-educate via Continuing Education

The educational mission of pharmacy schools extends to the practicing pharmacist. The changing roles of the pharmacist which I have described have created a need for continuing pharmacy education that will keep pharmacist practitioners abreast of the patient service and drug developments in the field. Public acceptance and success of the new pharmacist depends in large measure of the ability of the entire profession to respond.

Adequacy of Research Support

The research capacity of schools of pharmacy has only begun to be tapped. Pharmacy biomedical research support from NIH has increased over 30% in the last three years. Unfortunately, just seven schools shared 77% of the total NIH support held by pharmacy schools, and only twelve schools (in 72) have current awards

totaling more than \$1 million. The need for pharmaceutical research support remains great and we are concerned that if Federal research support shrinks too much, the potential developed in our schools during the 1970s will be effectively closed off.

Our problems are not unsurmountable. Our schools have the will to survive. Because of the importance of our mission to society, we are firmly committed to our goals. The continued cooperation and dialogue with Congress are as vital as ever before.

OUR VIEWPOINT OF THE FEDERAL ROLE

Recognize Our New Roles

The first thing which we ask of you is deceptively simple. We ask to be recognized. The contributions of clinically trained pharmacists should be encouraged by including them in the development of any new Federal programs where their expertise can be brought to bear. Programs in home health care, self care and consumer education are examples in this respect. To promote effective drug use and reduce unnecessary utilization of more costly levels of care--THINK PHARMACY!

Modify Reimbursement Mechanisms

We look for further recognition through the reform of reimbursement mechanisms for pharmaceutical professional services provided under Federal programs. Specifically, compensation should be based on professional services and consultations and not solely on the number of prescriptions products dispensed. Pharmacy is the only health profession reimbursed for products delivered but not the service rendered. The failure to provide compensation for service prevents many pharmacists from more actively pursuing such activities as professional counselling, drug interaction monitoring and drug utilization review. In fact, since such counselling may result in decreased drug use, there is a disincentive for these activities! Alternative reimbursement means should be explored that provide positive incentives for pharmacists to guide consumers in the rational use of drugs.

Provide Institutional Support for Pharmacy Colleges

We need continued Federal support of our academic programs to help our efforts to develop innovative programs designed to meet the opportunities of the 1980s. We need base line support to pharmacy schools to maintain clinical pharmacy educational programs; such support should not be tied to the number of students enrolled. We would also like to see enhanced basic institutional support with a dedicated pool of funds to be awarded on a competitive basis for development, operation and evaluation of training programs that meet identified national priorities.

Our schools know that continued Federal financing of pharmaceutical education must be based on documented pharmacy practice achievements related to national health priorities, including cost containment. We are convinced that the direct patient care activities of pharmacists and the direction of contemporary pharmaceutical education and research have had a positive impact on the quality of patient care and on health care costs. Evaluative research verifies that support of pharmacy education is a prudent investment that will justify itself in sustained, longterm life and cost savings.

Maintain Student Support

To help counteract the problems faced by our students in financing their education, we urge that a variety of student loans and interest subsidies should be available at the Federal level to assist needy students with educational costs. Pharmacy education is seriously concerned by the breadth and depth of Federal aid program budget cuts now being considered. The effects of across-the-board reductions in scholarships and loans will be devastating to our students. Minority and disadvantaged students should continue to be directly aided and assistance should be provided to schools for recruitment and retention programs.

You can also assist colleges of pharmacy in maintaining realistic tuition levels through institutional support so that middle and low income students will not be excluded from the profession.

Support and Encourage Retraining of Pharmacists

It is hoped that schools of pharmacy will be encouraged to answer the continuing education and retraining needs of pharmacists in innovative ways. In order to maintain professional productivity, these pharmacists will require non-traditional educational programs that will permit their continued employment while they are upgrading their competency. Seed money will be needed to develop these new educational technologies and to encourage development of these programs.

Support Pharmaceutical Research

Even in these difficult fiscal times, we need continued and expanded support for our important research efforts. Federal programs should emphasize the value of applied research in the areas of drug action, interaction, bioavailability, dosage formulation and drug taking behavior. Clinical research in pharmacology among children and the aged should be augmented. Stable, long-term funding should be provided for the National Institutes of Health and political influence on scientific programs should be minimized. We also ask for recognition by Federal agencies that our pharmaceutical scientists conduct important research of a quality that deserves Federal support.

We, therefore, urge your support of new initiatives for pharmacy education to address the nation's health needs.

CONCLUSION--DIRECTION OF THE PARTNERSHIP

The Pharmacy/Federal partnership has accomplished a great deal over its life span. Its usefulness has not been exhausted and the partnership can continue to be productive. Pharmacy schools are ready to pursue Congressional interests as well as to develop with you some of the ideas expressed today. Contemporary pharmacy is still in its adolescence and needs nurturing and support; however, it does not require a Federal parent making decisions. Schools of Pharmacy seek your interest and participation and will benefit by selective Federal support of our educational and research programs. At this critical junction we need continued, interactive communication to determine the future direction of our worthwhile partnership.

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STATEMENT OF JACK BILBY

Mr. BILBY. Mr. Chairman, my name is Jack Bilby. I am a fifth-year pharmacy student at the University of Maryland School of Pharmacy.

As a student who has required federally supported financial assistance in the forms of a basic education opportunity grant, a guaranteed student loan and health professions student loan I would like to address the subcommittee on the subject of student aid.

Students and their families are very concerned about how high the costs of education can go before we can no longer afford to be educated, particularly in view of the reductions being considered in Federal student aid programs. My tuition even at a State school has been increasing steadily. Private pharmacy school tuitions have increased even more markedly.

We realize that in comparison to other health professions student tuition pharmacy tuition is relatively modest. But just as pharmacy tuition is well below that of medical schools, the expected annual income of a pharmacist is well below that of a medical doctor.

At the beginning of our careers my classmates and I can expect to earn an average salary of about \$20,000 and at today's rates our salaries are not like to exceed \$30,000 at their peak. For this reason pharmacy students like myself are reluctant to incur large long-term debts in financing our education.

We are most appreciative of the efforts of this subcommittee to continue the existing health profession student assistance programs. The changes in these programs posed by H.R. 2004 seem for the most part positive and fair. On behalf of students who will follow me into pharmacy I do request that the subcommittee consider the following:

First, identifying a portion of funds to be authorized specifically for pharmacy students under the exceptional financial need scholarship program.

Second, clarifying that pharmacy students can have HEAL interest payments deferred while in approved residency programs and postgraduate programs.

Third, encouraging the participation of pharmacists in the National Health Service Corps. Because pharmacists are now the best distributed and most accessible health professional they have not been an integral part of the Corps. However, even though there are few absolute pharmacist shortage areas, there is a need to increase the number of pharmacists practicing expanded clinical roles in rural and other underserved areas.

Mr. Chairman, thank you for the opportunity of speaking to the subcommittee. It has been an honor and a unique learning experience for me.

Mr. LUKEN [presiding]. Thank you, Mr. Bilby, gentlemen.

The gentleman from Pennsylvania.

Mr. RITTER. I have no questions at this time, Mr. Chairman.

Mr. LUKEN. Well, it is very important that this committee receive the testimony and the contribution from you gentlemen due to your specialties and that the committee and the Congress recognize the unique situations of each of your different disciplines.

I take it that what you are saying is at least in part, what the AMA testified to, that as far as institutional support is concerned that you believe you are going to need continuing support in order to provide stabilization within your respective fields.

Does anybody want to comment on that?

Dr. Schlegel.

Dr. SCHLEGEL. Yes, I believe that is true. The mechanism for support though I think all of us recognize may need to be looked at.

Dr. ABT. I think that is true for veterinary medicine also.

Mr. LUKEN. I think what you are saying is that insofar as governing the manpower supply, since we are looking at a manpower bill of representatives of your professions who are serving the public, that Government does have a responsibility that no one else is going to exercise.

Would you want to comment on that?

Dr. BAERG. In reference to podiatry, the five existing colleges virtually serve as a nationwide supply. Irrespective of their State location they serve as a national resource for the entire country and on that basis I think we could certainly endorse that approach.

Mr. LUKEN. And you have found in the past that studies have shown that there has been actually a shortage of podiatrists?

Dr. BAERG. Right.

Mr. LUKEN. But you have more in your schools now. What is the present status or what are the prospects?

Dr. BAERG. Well, the prospects are virtually landlocked with our existing enrollment reaching a plateau. However, our proposal here is in the form of a possible special project that would allow us to develop innovative methods of expanding our clinical training programs in area health centers and medical centers distant from the main body of the college, developing clinical campuses, as it were, in those shortage areas. That has been the innovative approach in addition to some possibilities of startup assistance.

Mr. LUKEN. Has that been tried?

Dr. BAERG. In several instances, yes, and proved to be very successful.

Mr. LUKEN. So it would in effect be a savings in relation to the amount that might otherwise be used in the form of a subsidy?

Dr. BAERG. That is correct.

Mr. LUKEN. Dr. Schlegel, did you have something to add?

Dr. SCHLEGEL. The only thing I would add is that I believe it is our philosophy that broad-based, ongoing institutional support of existing programs may not be appropriate but we do see a role for the Federal Government in identifying national health needs and then providing seed money to get things started and then gradually withdrawing and allowing the existing facility, the college of pharmacy, to support that program on an ongoing basis. We would advocate your consideration of that kind of support for colleges of pharmacy.

Mr. LUKEN. How about the student loan? Mr. Abt, you mentioned the student loan.

Dr. ABT. Yes. We have some concerns here that are foremost in our thinking. As with podiatry, of course veterinary medicine is also a national resource. There are not veterinary schools in all of

the States of the country. There are 25 currently with students enrolled serving the needs of the entire Nation.

The problem that focuses for us on the student and the student assistance approach is that the high cost of veterinary education, which is in the neighborhood of \$20,000 per year in terms of actual costs for the educational process itself, leads at the present time to a need to share the costs between the student, the States, and hopefully the Federal institutions because of the national resource in the nature of veterinary medicine.

In addition to this, the earning power of the veterinarian does not begin to compare with our colleagues in human medicine. Data is readily available and we can provide you with copies of if you would like.

Mr. LUKEN. That is not necessarily the popular view, Mr. Abt.

Dr. ABT. No, I know it. That is why I wish to bring it up because it is a widely held mistaken belief that the veterinarian earns the kind of salary that the physician earns and they do not. The average starting salary in this country is \$18,000, 18 to 18.5, for the new graduates. At the end of 9 years of working in the profession the salary is in the neighborhood of \$30,000 for the median salary in the country.

Now, we are talking about a profession that does not have the earning capacity and hence the ability to repay the loan burden that is available to other professions. I have data which I can give you in great detail for the University of Pennsylvania students which shows that the current senior class has a median graduating debt of \$33,725; that is the class that is currently in the senior year.

When one compares that kind of debt burden to the earning power, and the earning power even 5 and 10 years later, then one has to be concerned with ways to reduce the burdens on the student.

Mr. LUKEN. We don't have any American television programs on veterinarians like they do in England. Maybe that is the problem.

Dr. ABT. No. The problems are apparently the lack of third-party payors, the absolute economic value of livestock and the needs for the veterinarian to provide for society's requirements in areas where the payment of fees for services does not have the same relationship to the value of animal life and health as it does in human medicine.

Mr. LUKEN. I just want to pursue this for 1 second and this will be my final question to you gentlemen.

I believe the proposal of the administration, and one that is widely advocated, is not to eliminate the guaranteed student loan program but to put qualifications on it and limit it to those in need and perhaps the needs would be rather liberally construed and liberally stated in the terms of minimums, and so on.

What would be your reaction to that?

Dr. ABT. Well, we would like to see it continue. We are not opposed to having reasonable limitations put on and we would support that approach for our needs, but we would like to see that the limitations of how much can be borrowed in the reformulation of the loan data be tied to reasonable interest rates and a reason-

able repayment period commensurate with the earning power of the borrower.

Mr. LUKEN. Thank you.

Mr. Ritter.

Mr. RITTER. I just have an inquiry. You mentioned that the average salary is \$30,000. Is that veterinarians working in an environment where they are salaried or does that encompass the entire profession including private practice?

Dr. ABT. That is a compilation of data collected by the AVMA for all segments of the profession. Breakdown data by different segments of the profession is available. There is relatively little variation within the different subcategories though. That number that I quoted was the figure at the end of 9 years of postattainment of the degree.

Mr. RITTER. Do most veterinarians work in private practice or are most associated with institutions?

Dr. ABT. The majority are still in private practice.

Mr. RITTER. One of the comments you made which intrigued me was that lack of third-party payors for veterinary services, if there is such a thing. Perhaps we can learn something about health care costs and the burgeoning salaries of some of our counterparts in the other professions by taking a look at the effects of third-party payments on increasing the country's vast burden of health care cost increases.

Thank you.

No other comments.

Mr. LUKEN. Thank you, Mr. Ritter.

Thank you, gentlemen, very much. We appreciate your patience in waiting, your testimony, and your contribution.

Our final witness this morning is Mr. Clark Jones from the California Statewide AHEC. He is accompanied by Dr. Merwyn Landay and Mr. John Payne from the New Jersey and the North Carolina AHEC's.

Mr. Jones, did you want to lead off?

STATEMENT OF CLARK JONES, ASSOCIATE DIRECTOR, CALIFORNIA AREA HEALTH EDUCATION CENTER, ACCOMPANIED BY JOHN PAYNE, DEPUTY DIRECTOR, NORTH CAROLINA AHEC, AND MERWYN A. LANDAY, D.D.S., PROJECT DIRECTOR, NEW JERSEY AHEC

Mr. JONES. Thank you, Mr. Chairman.

I am the associate director of the California Area Health Education System. With me are John Payne who is the deputy director of the North Carolina program, and Dr. Merwyn Landay who is program director of the New Jersey College of Medicine and Dentistry project.

We appreciate this opportunity to testify on behalf of all of the 20 AHEC projects in the country.

Mr. Payne represents Dr. Eugene Mayer whom the members of the committee may recognize as a national leader in the AHEC program. I speak for Dr. Malcolm Watts, our project director and for the deans of all of the schools of medicine in California who met on Tuesday to reaffirm their support for this program and to ask the support of this committee as well.

The Congress first authorized the national area health education center program in 1972 to address the serious problems of geographic and specialty maldistribution of health care providers. Repeated evaluations of the program, including the Appropriations Subcommittee staff's study of 1978 and the 1978 General Accounting Office study and the Carnegie studies of 1976 and 1979, testified to the success of the program in helping to meet national health manpower goals.

Congress recognized the contribution of the first generation of projects when it provided new authorization under section 781 of Public Law 94-484. We believe that the reasons for this widespread support are, first of all, that it works, that it accomplishes the objectives of the legislation.

Second, that it mobilizes the university and local resources in a partnership with the Federal Government.

Third, it causes an enduring change and not a temporary change. It is specifically targeted and it is measurable.

Finally, it necessarily involves the agencies which are required to make it work, that is local and State agencies, professional societies, students, and major health science centers.

Maldistribution of health providers, especially primary care physicians continues to be a serious barrier to access to personal health care. In California, for example, despite the availability of large numbers of physicians in some areas significant portions of the State are seriously deficient in health manpower.

The Division of Health Professions Analysis of the Department of Human Services has thus far determined that more than 2.7 million Californians reside in areas which are primary care manpower shortage areas. Similar shortages exist in all of the AHEC target areas.

The first generation of projects was focused largely on rural areas, Illinois, North Carolina, South Carolina, West Virginia, Maine, California, Texas, North Dakota, Minnesota, New Mexico, and Missouri.

The needs of rural areas remains a high priority. The national program has recently accepted the challenge of the needs of underserved central cities such as Dr. Landay's project in Camden, N.J., in Pittsburgh, in Baltimore, Hartford, Los Angeles, Boston, eastern Virginia and others.

The valuable lessons learned from the projects originally funded in 1972 are being applied now to the needs of these underserved urban poor and minority communities. The success of the first generation of AHEC projects has been due in large part to the continuity provided by the 5-year contracts under which they were originally funded.

We believe that the current generation of project requires a similar level of certainty and stability and we urge full funding at a level of \$21 million for the 1981-82 fiscal year for this new generation of projects.

Several of the original projects have modified their priorities as they moved toward the achievement of their early priorities. In Mr. Payne's State of North Carolina, for example, the AHEC program has recently announced a major initiative in nursing education.

While continuing to support an extensive network of primary care physician education principally with State funds the project will now address in a more direct way the critical needs for nurses throughout the State.

We recommend a total of \$1.7 million to fund continuing evaluation of the impact of the original programs and to fund modest new programs among these projects. This modest investment will allow the Government to capitalize on the previous investment it has made in support of these programs.

We also recommend that the Congress consider a limited number of new starts. Serious problems of geographic and specialty maldistribution exist in a great many places in the country still and the proven AHEC intervention strategy could be usefully applied in both urban and rural shortage areas.

Finally, we recommend that the Congress consider modifications to the language of the authorizing legislation to the regulations to permit some much needed flexibility. The present legislation does not adequately meet the needs we believe particularly of multi-institutional statewide projects such as those in California, Massachusetts, Ohio, and North Carolina for local and regional autonomy within the broad Federal roles.

Mr. Chairman, thank you again for this opportunity to appear before you and my colleagues and I will be happy to answer any questions you may have.

[Testimony resumes on p. 427.]

[Mr. Jones' prepared statement follows:]

The National Area Health Education Centers Program

"AHEC"

March 9, 1981

Authority: Public Law 94-484: "The Health Professions
Educational Assistance Act of 1976"
(Sections 781 and 802)

Program Description

The AHEC Program was created by The Congress as one method for improving the geographic distribution of physicians and other health personnel in rural areas and inner city areas. As of January, 1981 there were 21 projects of which 10 were originally funded in 1972 under authority of Public Law 92-157: "The Comprehensive Health Manpower Training Act of 1971." The remaining 11 projects were funded in various years beginning in 1977.

Several studies have given a clear indication of the success of the National AHEC Program in helping to overcome problems of geographic and specialty maldistribution of physicians.

These studies include:

1. 1978 Report of the U.S. Government Accounting Office

By the Comptroller General, Report to the Congress of the United States, Progress and Problems in Improving the Availability of Primary Care Providers in Underserved Areas, HRD-77-135, August 22, 1978.

2. 1978 Report of the U.S. House of Representatives Appropriations Subcommittee on Health

A Report to the Committee on Appropriations in the U.S. House of Representatives on Area Health Education Centers Programs addressed by the Department of Health, Education and Welfare by the Survey and Investigations Staff, February 24, 1978.

3. 1976 and 1979 Reports of the Carnegie Council

- 1) Progress and Problems in Medical and Dental Education, Federal Support Versus Federal Control, A Report of the Carnegie Council on Policy Studies in Higher Education, Jossey-Bass Publishers, San Francisco, CA, 1976.
- 2) Area Health Education Centers, The Pioneering Years, 1972-1978, A Technical Report for the Carnegie Council on Policy Studies in Higher Education, Charles E. Odegaard, 1979.

4. 1980 Report to The Congress by the Secretary of the Department of Health, Education, and Welfare

An Assessment of the National Area Health Education Centers Program, November 9, 1979, DHEW Publication No. (HRA) 80-33.

5. 1980 Report of the Graduate Medical Education Advisory Committee (GMENAC)

--although this Report concludes that there will be an aggregate surplus in the number of physicians by the year 1990 or 2000, it also concludes that geographic maldistribution of physicians continued to be a serious problem and indicates that the AHEC Program is one of the initiatives designed to help overcome this problem.

The National AHEC Program is funded out of the Division of Medicine of the Bureau of Health Professions of the Health Resources Administration of the Department of Health and Human Services. Since October, 1972 The Congress has appropriated \$144.2 million for the national program.

The National AHEC Program is characterized in the following manner:

1. It is a program of education and training of physicians and other health manpower based in the academic medical

center. Twenty (20) medical schools participate in the program as prime contractors. Subsequent subcontracts serve to involve fully one-third of the nation's medical schools in the National AHEC Program.

2. It is designed to bring the education and training of health manpower to underserved communities via the development of new regional training centers (usually community hospitals or community health centers) that assume responsibility for helping to meet the health manpower development needs of a defined number of rural counties or inner city neighborhoods. Today the 21 AHEC projects account for 76 regional centers called AHECs.
3. It has had a measurable and significant impact on the geographic and specialty maldistribution of physicians and other health manpower in underserved areas.

In addition, the National AHEC Program demonstrates the following important characteristics:

1. It is based on incentives and voluntarism.
2. It reflects an approach whereby federal funds are provided to states and regions to develop manpower programs that meet local and regional needs in the context of national goals.
3. It demonstrates that most projects have been able to use federal AHEC funds to catalyze state, local and other funds which have assured that most of the AHEC projects funded in part by the federal government in

1972 will survive--in whole or in part--following the cessation of federal funds.

--as noted, since 1972 The Congress has appropriated \$144.2 million for the National AHEC Program. In that period of time over \$291.5 million of state, local and other funds have also been catalyzed by this federal investment.

4. It demonstrates the fact that the federal government can catalyze regional activities which meet unique local circumstances through the flexible statutory requirements and minimal rules and regulations. This federal approach has been critical to the success of the Program, especially for the projects originally funded in 1972.

The projects support funding of the National AHEC Program for FY 1982 at the level of authorization listed in HR 7203 as passed by the U.S. House of Representatives in 1980. This level is \$28 million. Further, the projects believe this authorization should be followed by authorizations of \$30 million for FY 1983 and \$32 million for FY 1984.

It is important to recognize that the foregoing levels of funding include funds for the start-up of new AHEC projects. Should The Congress be interested only in assuring the development of those projects to which it already has a contractual obligation then an authorization level of only \$23 million is needed for fiscal year 1982, \$25 million for fiscal year 1983, and \$27 million for fiscal year 1984.

Program Accomplishments

As noted, the National AHEC Program has had a measurable and significant impact on the distribution of physicians and health manpower. This is particularly true of the eleven projects originally funded in 1972. The remaining projects funded subsequent to 1977 are too young to have had an impact on manpower distribution. For this reason, the accomplishments of the National AHEC Program will be listed in two categories according to date of initial federal funding of the projects.

I. AHEC Projects Originally Funded in 1972

Pages 6 - 12.

II. AHEC Projects Funded Subsequent to 1972

Pages 13 - 19.

Projects Funded in 1972CALIFORNIA

California began a Statewide AHEC Program under new authorizing legislation in 1979, but one of the original eleven projects also took place in California starting in 1972. The principal target area was the Central San Joaquin Valley. The Health Science Centers were the University of California at San Francisco (UCSF) and the University of California at Los Angeles (UCLA). The major objectives of the Central Valley program have been accomplished, and as federal funding draws to a close dramatic results can be counted. For example:

- Before the project began there were virtually no medical student rotations to the AHEC area. Now there are 180 student rotations per year, many of which are core clerkships in the UCSF Medical School curriculum. Faculty appointments for practicing physicians in the target area have increased.
- Physician resident training in primary care specialties has risen during this period from 12 to 129.
- A series of consortia of small hospitals was organized to conduct continuing education for physicians and other health professionals throughout this area which is nearly as large as the state of South Carolina; this service continues without federal funding, paid for by fees and subscriptions.
- The impact of these physician education programs is shown by a survey of physician population done in the sixth year. It compares areas which had significant AHEC educational activity with similar areas which did not have AHEC assistance. Positive changes in the AHEC-impacted areas were substantial, compared to a decline of physicians in the non-AHEC areas. The AHEC areas showed a net gain of 152 physicians, an increase of more than twenty percent.
- Other major achievements included development of a new dental residency program fed by a steady stream of dental students; an extensive network of nurse career ladder programs from nurse aide to associate degree programs, Bachelor of Arts Degree programs, and Master's-level programs, as well as two nurse practitioner programs; a wide range of allied health training activities; and a strong, enduring community organization.

Much of this program has been transferred to other funding and other elements have been closed as the need was met. No federal support is expected after this year.

The California Area Health Education Center System, begun in 1979 under authorization of Section 781 of PL 94-484, builds upon the demonstrated success of the local project begun in 1972.

ILLINOIS

- 40% clinical training of all medical students now in community hospitals.
- 112 family practice residents serving 42 counties.
- Retention of family practice residents - 70%.
- Over past nine years, \$70 million in State funds went into regionalization.

MINNESOTA

- AHEC has provided training for approximately 1,900 students in ten different health fields. AHEC has:
 - Provided rural preceptorships for 470 medical students and rural clinical rotations for 170 residents.
 - Provided over 500 registered nurses with off-campus courses and nurse practitioner training, both at the undergraduate and graduate levels.
 - Provided rural preceptorships for nearly 150 dental students.
 - Assisted the Medical School to develop seven different clinical preceptorships to improve the supply of physicians in underserved areas.
 - Assisted in the creation of the position of Assistant Vice President for Health Sciences Outreach.

MISSOURI

- Has encompassed all disciplines of allied health (including dietitians and radiology technicians) into an organized network of C.E. programming, particularly in west central and northwest areas.
- Has produced and distributed an audio-visual catalogue of over 800 programs available at no charge, for use by area health care professionals and hospital libraries as well as students in the field.

- Established an In-WATS line for learning resource requests of both reproduction and on-line search. In addition, most A/V programs are requested this way from area professionals and institutions. All facilities at our health science library are available to participants.
- Has conducted a very successful minority recruitment effort called Summer Scholars 1980 for area high school juniors and seniors. Another program is planned for 1981 in Kansas City, and also for the St. Joseph area. Other talent identification program efforts have been extremely successful in identifying students at this level.
- Participation in three study tours to acquaint health science students with career possibilities in the state of Missouri, (medical, pharmacy, dental and nursing) as well as a very active externship/preceptorship program in the areas of medicine, pharmacy, dentistry, and nursing. Over two-thirds of the medicine rotations are in primary care/family practice settings.
- A strong nurse practitioner program in southwest Missouri, providing externship experiences and C.E.
- Established a viable working liaison with the health science schools of UMKC and UMC, particularly in nursing and allied health.

NEW MEXICO

- Developed an organization of Indian health program administrators and planners.
- Developed and sustained health professional training programs for nurses, emergency medical technicians, physician assistants, medical technologists and community health representatives on the Navajo.
- Supported over 300 Indian students in various health training programs. Of those who have completed their training, over 85% are working with Indian people.

NORTH CAROLINA

- Medical student education is now occurring on a regular basis in over half of North Carolina's 100 counties. The proportion of North Carolina medical school graduates who are choosing to practice in North Carolina has increased dramatically since the start of the AHEC Program. In the 1960's only 30% of the State's medical school graduates were eventually locating in North Carolina. That number has risen to over 40% of graduates since 1972 and the student body has doubled in size.

- Primary care residency training now takes place in all nine AHEC regions of North Carolina. Historically, the State has retained slightly over one-third of the residents trained here. In 1980, two-thirds of AHEC-trained primary care residents remained in North Carolina to practice.
- From 1973 to 1978, the improvement in North Carolina's population/physician ratio was 20% compared to 15% for the rest of the U.S. North Carolina's rural counties have improved their physician/population ratios significantly greater than other rural U.S. counties.
- A process is in place to direct major program initiatives toward improving the recruitment and retention of nurses in the State's hospitals and other health agencies. As an initial step, a major statewide nurse manpower survey was conducted by AHEC which documented 1,500 budgeted vacancies for RNs in North Carolina in 1980, and showed the annual turnover rate of RNs to be 23% in the State's health care agencies.

NORTH DAKOTA

- By means of the AHEC contract, North Dakota developed its degree-granting medical school, a statewide program in which community physicians are the faculty and community hospitals are the campus. Since the inception of AHEC, North Dakota's medical school has graduated five classes, a total of 200 new physicians.
- Also due to the AHEC contract, North Dakota now offers six primary care residency programs throughout the State - four programs in family medicine and one program each in internal medicine and obstetrics-gynecology. These six programs train 62 residents per year.
- In 1972, the year of the AHEC contract award, North Dakota's ratio of physicians to 100,000 population was 85.1. In 1977, five years into the AHEC Program, North Dakota had climbed to a ratio of 108.0. Although this ratio does not yet approach the national average, it represents a significant advance in physician manpower for North Dakota.

SOUTH CAROLINA

- Increased extramural residency positions from 69 in 1972 to 337 in 1980; three-fourths of these are primary care.
- Senior medical student rotations to rural areas have increased from 27 weeks in 1972 to 995.5 weeks per year in 1980-81.

- Minority physician recruitment programs have led to an increase from 39 minority physicians in 1976 to 84 minority physicians in 1980.
- Seven AHECs now form a statewide network for health education for clinical training of undergraduate, graduate and continuing education for practicing health professionals.
- Statewide learning resource network supplies rural hospitals with modern AV materials, biomedical communications linkages, and library resources.
- AHEC has retained 60% of all residents trained over the past three years; 56% of all residents over its history have been retained and are now practicing in South Carolina.
- 100% of all senior dental students are involved in AHEC's extramural dentistry rotations.
- 80% of dental students taking part in the dental rural practice site survey have chosen a practice site in the same or similar rural underserved area.

TUFTS

--Undergraduate Medical Education

- a. Development of third and fourth year clinical clerkships in two medical centers, and fourth year preceptorships in six rural sites to support an average of sixteen third year complete clinical third year rotations in each of the eight years and a total of 11.1% of all undergraduate clinical education at Tufts in AHEC sites.
- b. Development of a tracking evaluation method which shows that students who participated in these programs have a significantly higher inclination towards locating their practices in non-urban locations, particularly in Maine where the AHEC has been located.

--Postgraduate Medical Education

- a. Development and/or expansion of four Family Practice Residencies in Maine where there were none prior to AHEC having a total of 20 first year positions and 62 residents in training at the end of the 08 year of AHEC funding. 78% of the graduates of these programs located their practice in Maine and 76% of those are in communities of 10,000 population or less.
- b. Expansion of the only other residency training program in Maine at the onset of AHEC from 34 to 89 positions.

--Continuing Medical Education

- a. Provision of 692 visiting professor clinical sessions in twelve sites, eight of which are rural.
- b. Provision of 85 weeks of guest residency visits to nine rural hospitals.

--Dental Education

- a. Provision of dental externships in six rural Maine communities with 147 students participating. Approximately 40% of these students eventually located practices in Maine.

--Nursing Education

- a. Assistance to the Family Nurse Associate Program of the School of Nursing at the University of Southern Maine. 71 graduates, all in practice in Maine, 42% in rural areas.
- b. Assistance towards expanding nursing education to two rural campuses of the University of Maine system and support for nursing continuing education via two-way telephone system.

--Allied Health

- a. Assistance to Southern Maine Vocational Technical Institute towards training of 48 respiratory therapy technicians.
- b. Assistance to SMVTI towards training of 285 emergency medical technicians either at basic or advanced EMT level.

--Assistance in the development and implementation of a new Consortium for Health Education in Maine as an ongoing mechanism to promote AHEC principles and objectives.

WEST VIRGINIA

- Increased primary care residency positions from 14 to 102 in three hospitals with significant retention in regions served by AHEC.
- Due to university relations through AHEC, there has been a decrease in the number of residents who are foreign medical graduates.

- Outreach program in Pharmacy utilizing some 63 remote sites is fully in place.
- A nine-chair dentistry clinic has been established as part of the AHEC center for use in the training of dental students and general practice dental residents.
- Continuing education programs are currently being taken to seven outreach sites throughout the AHEC area with programs specifically designed to meet regional needs.
- Continuation of the program beyond federal funding has been offered by State and other sources.

AHEC Projects Funded Subsequent to 1972CALIFORNIA

The California Statewide AHEC program has been in operation for one and one-half years. It has organized all eight fully-developed medical schools into a cooperative relationship with the major state health agencies and with a developing network of local AHECs. Twelve local centers are now in planning or development phases and four more are expected to be added in fiscal year 1983. Of these, nine will have an urban focus, while six will serve the needs of rural areas. Much of the successful experience in the Central Valley will be useful in the new endeavor, but new approaches to the university-community partnership also are being developed in urban areas where the barriers to health care are significantly different from those in rural areas. Although some parts of the state are "over-doctored", the Division of Health Professions Analysis, DHHS estimates that 2.7 million people reside in primary care health shortage areas in California and that 871 additional primary care physicians are needed in these areas. This is a classical case of maldistribution which has resisted solution for decades. The AHEC program has proven to be an effective remedy to this problem. The California AHEC project is a potent alliance of the educational resources and local and state agencies needed to overcome the problem of maldistribution of health professionals. These efforts are carefully targeted to areas and populations of need and are supported by the California Medical Association and other important professional groups. In fact, there are fourteen active professional, student and community committees which are designing and evaluating educational components. In selected areas of severe manpower shortage, we will increase training opportunities (over 100 new primary care physician residency positions are planned to be added), but in other cases we will rely on other mechanisms to induce distribution, including recruiting and retention programs, and enhancement of the professional environment.

COLORADO

- Medical student core clerkships exist now in four AHEC communities where none previously existed. In 1980-81 100 students will study medicine, pediatrics, surgery, obstetrics-gynecology, and/or psychiatry in community hospitals away from Denver.
- Preceptorships for medical students have been greatly expanded since 1977 when only 5-10 students per year participated. In 1980-81, over 40 students will work with rural Colorado physicians through the AHEC Program.

- Nursing baccalaureate students are using rural Colorado hospitals and health departments for part of their clinical education. For the first time these rural facilities have an opportunity to recruit baccalaureate nurses for their community and graduates are returning to the sites of their rural experiences to work.
- The AHECs offer continuing education to practicing health professionals in rural areas. During 1980-81 an estimated 4,000 rural professionals will receive continuing education close to home.

CONNECTICUT

- AHEC has provided key support in establishing a required primary care clerkship which will involve 70 fourth year medical students each year in urban health experiences in underserved inner cities.
- Supported the expansion of a family medicine residency program to include a significant focus on urban and community health issues and needs.
- Developed contracts with seven health professions schools including: medicine, dentistry, allied health, public health, nutrition sciences, nursing, and social work to place students in discipline-specific and inter-disciplinary experiences in AHEC-developed and sponsored sites.
- Supported the development and implementation of a school nurse practitioner program to upgrade the clinical skills of school nurses. This has increased their ability to function in a multi-disciplinary environment and has expanded their understanding and utilization of community health resources.
- Developed a university-wide approach to minority recruitment and development, including linkages to public schools, other educational and training programs in the target area and branch campuses of the university.
- Has utilized the resources of key agencies within the Black and Hispanic communities to plan, develop and implement educational programs for students, health practitioners and community residents.

KANSAS

- While only in the middle of its second year of existence, the Western Kansas Rural AHEC Program has already planned, developed, and/or conducted over 30 community-based programs in continuing education for nurses and allied health professionals. The programs conducted to date have attracted over 500 individuals in nearly 15 different communities.

- In addition, community-based continuing education programs for rural physicians have been initiated through the AHEC Program and have been conducted by medical school faculty in cooperation with medical specialists in Northwest Kansas. Over 150 rural physicians in six different communities have attended programs ranging in content from: medical ethics to toxic shock syndrome. Dozens more programs have been requested throughout the regions for the upcoming year.

MARYLAND

- Consists of three active AHECs (two urban and one rural) with plans being implemented for an additional rural center.
- One of the urban centers is unique in the Nation because it is designed to address problems of ready access to and maldistribution of health care providers for a specific geriatric population.
- The numbers of students, both graduate and undergraduate, and residents that have rotated through the three centers for the past 1 1/2 years are as follows: Medicine: Undergraduates - 67, Graduates - 26; Dental: 11; Nursing: 86; Pharmacy: 48; Allied Health: 27, for a total of 265.
- To date, three physicians, four dentists, four social workers, four nurses, six nurse practitioners, and three pharmacists have located in a designated underserved area in the State following their experience in the Cumberland AHEC Program.

MASSACHUSETTS

- The Massachusetts Statewide Area Health Education Center Program is a partnership effort among three medical schools (University of Massachusetts Medical School/Worcester, Boston University School of Medicine, and Tufts University School of Medicine), ten other health professions schools and programs of these universities, and community-based institutions which have planned or will plan local Area Health Education Centers (AHECs). The Program is federally supported and was initiated in October, 1978.
- Established four regional AHECs, and is planning two additional centers.
- Assisted in the establishment of a primary care preceptorship program at the University of Massachusetts Medical Center, required of all students.

- Assisted in the implementation of residency training in inner city Boston health centers and public schools, and in rural sites in Western Massachusetts effecting a total of 33 primary care residents.
- Increased nursing graduates in Western Massachusetts by 12 graduates per year, developed new training affiliations in hospital and home health care settings for nursing students, fostered career ladder opportunities for ADN nurses by facilitating transfer to BSN programs, and funded the development of a family care nurse practitioner program.
- Assisted in the establishment of a preceptorship program for dental students in Boston neighborhood health centers.

NEW JERSEY

- The New Jersey AHEC has put its first Area Health Education Center (the Greater Camden AHEC) into operation on October 1, 1980, and is scheduled to put its second AHEC into operation (the Central Camden AHEC) on October 1, 1981. Both of these Area Health Education Centers are dealing with the complicated health care delivery and manpower problems of the urban inner city of Camden.
- Programs involving all AHECs:
 - a. Consumer Health Education Program for degree students
 - b. Health Care Management Program
 - c. Continuing Education Program
 - d. Learning Resources Program
 - e. Social Work Program

Almost all of these are either new programs or significant extensions of these programs into urban areas.

- Numbers of Students - In our first operations year of our first AHEC, which is the present year 1981, we have had the following student rotations:
 - a. Undergraduate Osteopathic Medical Students - 29 students into the urban area.
 - b. Undergraduate Dental Students - 83 students rotated through the area.
 - c. Allied Health - 6 physician assistants rotated through the area.
 - d. Bachelors of Science in Consumer Health Education - 10.
 - e. Health Careers Exposure at the High School level - 620.
 - f. Medical Social Services - 1.
 - g. Nutrition & Dietetic Students - 109,

for a total estimated number of students interacted with and rotated through this urban area in 1981 of 858.

- Continuing Education - We have had an estimated 32.3 days of Continuing Education spanning most health fields.

OHIO

- Ohio's program is addressing through regional education activities those problems associated with a rural Ohio population which has shown an 8% increase while the physician-to-population ratio has remained constant during the same time period. Problems associated with underserved urban areas are being addressed by programs being developed in Cleveland, Youngstown, and Cincinnati.
- Organizationally, the University of Cincinnati College of Medicine serves as the prime contractor, and then subcontracts with the other six medical schools in Ohio for the planning, development, and operation of regional AHEC programs. Regional programs at the University of Cincinnati College of Medicine, Northeastern Ohio Universities College of Medicine, and Case Western Reserve University are in the third year of the program and are operating centers in Georgetown, Youngstown, Akron, and Cleveland. The Wright State University School of Medicine will begin its third year on April 1, 1981 with an operation of a Center in Dayton. The Medical College of Ohio, The Ohio State University College of Medicine, and Ohio University College of Osteopathic Medicine are now conducting developmental activities and have established Centers in Sandusky, Lima, Columbus, and Athens.
- In addition to the medical schools, 24 schools or programs of the other health professions are participating actively in the Statewide Program. These include dentistry, nursing, pharmacy, and allied health. Students from these disciplines as well as medicine are being trained throughout Ohio.

PENNSYLVANIA

- Medical interviewing was completed by 52 students and 86 students completed the Introduction to Patient Care Course.
- Seven students elected clerkships at St. Margaret's and Shadyside Family Practice Residencies as part of the Primary Care Senior Elective.
- Coordination and liaison with family practice residencies by six specialty coordinators (i.e., community medicine, psychiatry/behavioral science, pediatrics, otolaryngology, medicine, obstetrics-gynecology) have included
 - (1) otolaryngology rotations for St. Margaret's and McKeesport residents
 - (2) a dermatology clinic for Shadyside residents
 - (3) first use of patient simulators at St. Margaret's
 - (4) psychiatric teaching, precepting and curriculum development at Washington, Shadyside and St. Margaret's residency program
 - and (5) a one-day otolaryngology workshop for residents of six Family Practice Residency Programs.

- 20 fourth year dental students participated in a rural clinical practice at Westmoreland Hospital Association and the Curry Memorial Home one day per week for 16 weeks (2 sessions).
- Fifteen third year dental students participated in an urban externship at Mathilda Theiss Health Center one day a week for 10 weeks.
- Four students who have agreed to seek employment in underserved areas have been enrolled in the Class of 1980 to be trained as family nurse practitioners. A unit on family and pediatric care has developed.
- Primary care management was addressed by a problem identification conference held in December, 1979 for 49 participants. This was followed by a May-June, 1980 seven-part seminar series addressing "Contemporary Concepts in Management for Health Services Professional."
- Coordination with rural health centers was affected by attendance at monthly meetings of administrative personnel.
- Community field placement sites for undergraduate and graduate clinical dietetics students have been secured (i.e., Alma Illery Health Center, Allegheny County Adult Services/Area Agency on Aging, Magee Women's Hospital, Mercy Hospital Ambulatory Care Center).

SOUTH DAKOTA

- Program was initiated in 1979, so is relatively new.
- Has already had an impact upon the recruitment and retention of physicians in rural areas of the State.
- Is conducting continuing education programs for physicians, nurses, and other health providers.
- Has helped to establish a statewide library/learning resource system for health providers in the State.
- Is cooperating with State agencies in conducting health manpower assessments for the purposes of documenting health manpower needs in the State and for determining State needs for health education.
- Designated by the South Dakota Board of Regents of Higher Education as the official planning body in the State for State-supported health education.

EASTERN VIRGINIA

- The Program is a combined rural-urban program involving four AHEC centers (2 urban and 2 rural) encompassing six counties, eight cities, and a predominant portion of HSA V (population 1.3 million) in Eastern Virginia.
- After only six months of operation, the Western Tidewater AHEC (Chesapeake, Franklin, Suffolk, Southampton, and the Isle of Wight) already includes the following components:
 - Ten formalized student training courses (in Medicine, Dentistry, Nursing, Pharmacy, and Allied Health) involving 160 students in over 7,500 hours of clinical training and exposure in rural AHEC settings; with several more expected to begin in the coming months.
 - Thirty-five (35) identified continuing education program needs which have been identified and have either already taken place or are currently being developed.
 - Three health careers awareness programs which have involved representatives from all of the AHEC affiliated health science training programs and have involved over 2,500 rural high school students (estimated 50% minority enrollment).
 - A functioning learning resources system.
 - The AHEC Program is already encompassing medical student preceptorships, clerkships, electives, and individual medical student projects; including a recent 10 week medical student preceptorship rotation for 62 students into AHEC service areas.
 - The AHEC Program has developed a strong Minority Affairs focus.
 - AHEC has already developed collaborative relationships with HSA V in developing comprehensive health manpower assessments in the area in Medicine, Dentistry, Nursing, and Pharmacy and demographic assessments of the medically underserved and critical health manpower shortage areas.

3/9/81mjl

3/16/81 Rev./mjl

Mr. LUKEN. Thank you very much, Mr. Jones.

Do you think there is evidence that the AHEC's have actually improved the distribution of health professionals?

Mr. JONES. Clearly we have some summaries of the outcomes of the early project that have been in existence long enough to have put into place these programs which take some time obviously to bring to fruition.

Mr. LUKEN. How many of those are there?

Mr. JONES. There are 10 programs that were originally funded that still are in existence. The written testimony will give you some examples of the achievements. I think my colleagues and I could give you a few pertinent examples now.

Mr. LUKEN. Would you.

Mr. JONES. In the case of California, the original target for the program was the central San Joaquin Valley which is an area about the size of South Carolina. There at the 6th year of the project we had achieved an increase in the number of physicians in that largely rural area of approximately 20 percent. That was due in part to new physicians being trained in programs that were established under the program and in part to the enhancement of the professional environment which could attract and, perhaps more importantly, retain physicians who were being lost through, in the case of that particular area, aging, retirement, and death to a very alarming extent.

So we had to arrest the trend, the downward trend, and then reverse the trend. That is happily a rather good example for a study. We recognize that there are other influences on the distribution of physicians besides our program, but in that instance there was a similar area, a larger area with similar characteristics nearby.

We were able to trace the population of physicians in the AHEC area and the non-AHEC area over a period of time and the correlation was so strong that we cannot help but conclude that it is cause and effect as well.

North Carolina has some particularly, I think, pertinent observations in that regard.

Mr. PAYNE. Thank you. I would like to give some from other States if I could that are of the original 10 projects now. In Illinois they have 112 family practice resident graduates that are now serving 42 counties. The retention of family practice residents in Illinois is about 70 percent.

In North Dakota the new residencies have been entirely created by the AHEC program. These include 4 family practice residency programs with 48 residents and 1 program each in obstetrics and internal medicine. There were no residents in North Dakota prior to AHEC funding.

In North Carolina we have 300 new primary care residencies throughout the State and 170 of these are in family medicine which is evidence for a major improvement in physician distribution with evidence to link AHEC into this.

For example, between 1964 and 1970 only 22 of the State's 100 counties showed improvement in their physician-to-population ratio. Between 1970 and 1977, 80 counties showed improvement with only 9 showing a worsening ratio. This improvement is in

large measure associated with an AHEC program and other Federal and State programs.

Mr. LUKEN. Is there anything you want to add, Mr. Landay?

Dr. LANDAY. Well, representing the nine States that have AHEC programs in urban areas we are using the approaches that have been effective in the rural areas and are also trying to develop by bringing university resources to these inner cities ways to get people to locate, health professionals to locate in the inner city. There are very different factors and barriers operating in the inner city. It is not green and lovely like the rural areas where AHEC started. It is concrete and a little unsafe.

So our principal activity, most of us just beginning our third year, we are 2 years old, is the creation and development of innovative ways to try and get people to locate. We are at that stage and that is a much earlier state. That is where they were in 1974.

Mr. LUKEN. If and when the Federal assistance would be terminated, what are the prospects of AHEC's continuing?

Mr. JONES. We have a great deal of evidence to indicate already that the bulk of the initiatives that were started under the first round of AHEC funding already has been transferred to other sources of funding where they need to be carried on, for example, the new residency programs and so forth.

In some instances there were projects which were self-limiting for the duration and we have terminated those programs where it was appropriate to do so. It is characterized by flexibility, but I think most important by the point that you make, Mr. Luken, and that is that it is not intended to be funding in perpetuity. It is intended to address a goal, meet an objective and then to be taken over by other sources of funding. The written testimony is replete with evidence of that process taking place throughout the system.

Mr. LUKEN. Dr. Landay.

Dr. LANDAY. Most pertinent I think is since 1972 the Congress has appropriated approximately \$144 million to the national AHEC program. In that period of time we estimate that over \$291 million of State, local, and other funds have been added to that Federal investment in the AHEC. So that is the catalytic process that is occurring.

Mr. LUKEN. All right. You have made a very valuable contribution. I am sorry that all my colleagues aren't here. What happened as you noticed was that those in the earlier panels took longer than expected and people have obligations that they had to fulfill.

We thank you very much for attending and for what you have given us and we will chew on it.

If there is nothing further, this session of the subcommittee will be adjourned pending the call of the Chair.

Thank you.

[The following statements and letters were received for the record:]

American Academy of Pediatrics



Mr. Chairman, this testimony is submitted for inclusion in the hearing record on renewal of P.L. 94-484. The policies and concepts contained herein are those of the American Academy of Pediatrics, an international medical association and children's advocate whose more than 22,000 members are dedicated to the well-being of infants, children and adolescents. The comments are derived in part from "The Future of Pediatric Education," August 1978, a report prepared by the Task Force on Pediatric Education, an organization comprised of 10 pediatric societies concerned with the health and welfare of children (see Appendix 1)* Several of those organizations have conferred with the Academy on specific points raised in H.R. 2004 as well. Thus, we believe you will find the Academy's views representative of virtually the entire pediatric community and indicative of the time and effort which we have devoted to the issue of pediatric education and manpower during the past several years.

To set the stage for our comments, allow us to attempt to define what has come to be known as the "new pediatrics." As the pediatric task force which we mentioned earlier conducted its investigations, it became clear that advances in prevention and control of traditional acute and infectious diseases were permitting the pediatrician to devote more time and attention to what had been relatively neglected areas -- chronic disease; the increasing number of behavioral problems of childhood and adolescence; and what we call biosocial problems -- those health problems socially induced or complicated by social and environmental factors. Because coping with the challenges of modern society will cause an increase in the incidence of biosocial problems, modern pediatric training must be directed more specifically to the treatment of those problems.

The content of experience in biosocial pediatrics should include normal and abnormal growth and development, basic behavioral science information, reactions of children of various ages to illness, education for healthy lifestyles and familiarity with the principal literature regarding child development. Residents should also learn about the nature of psychologic and achievement tests, the principal psychologic therapies, the principles of psychopharmacology, and the techniques of family counseling. They should be familiar with the developmental characteristics of the parent-child interaction, child care practices and dysfunctions in parenting.

Residents should learn to manage such family crises as death and bereavement, suicide attempts, sexual assault, accidents, child abuse, birth of a defective child, separation, divorce, abortion, and a wide range of common behavioral disorders. Furthermore, they should be able to work with the family to resolve problems in parenting, well child care, adoption/foster care, school adjustment, and learning. They should be familiar with the role of the pediatrician in the management of disease states in which psychological elements play an etiologic or contributory role.

* The report referred to may be found in the subcommittee files.

There has been also a dramatic increase in our recognition of child health problems associated with poverty, a deteriorating physical environment, changing family structures and other social and psychological factors. There is growing evidence that encouragement of health promotion and changes in lifestyles may become more important than medical intervention in affecting morbidity and mortality. The pediatric community recognizes that pediatric education must respond to these changes in child health needs. We ask Congress to follow suit by authorizing the funds to allow us to develop and maintain an educational program relevant to those needs.

Pediatric programs have, in fact, begun to evidence a shift in emphasis toward treatment of biosocial disorders through a strengthening of ambulatory training. But the shift has been slight, and the bulk of pediatric training still takes place in hospital settings even though the burden of care for children with such problems remains largely in the community. We simply cannot continue to all but ignore the relationship between biosocial and developmental disorders such as early family adjustment difficulties and school failure and the adverse health effects of those problems. A recognition of that relationship mandates pediatric education which emphasizes the processes of human growth and development and their relationship to health and disease.

Because pediatrics is a primary care discipline, and because most pediatric problems are best handled on an outpatient basis, pediatric education should utilize the skills and demonstrate the commitment to personal, continuous care practiced by the general pediatrician. The current preponderance of hospital-based teaching in the pediatric curriculum is one indication of the dissonance between current pediatric education and the health needs of children. By the completion of formal postgraduate training, most pediatricians are extraordinarily skilled at diagnosing and managing illness, especially that of hospitalized children. As a consequence of concentrating pediatric resident education on illness, many if not most pediatric residents have only a rudimentary knowledge of the concept of normality and particularly of the variability surrounding the "average" with regard to child development and health status.

In the future, pediatricians will be called upon more and more to manage children with emotional disturbances, learning disabilities, chronic illnesses and other problems of a developmental, psychological and social nature. They will provide increased amounts of health care to adolescents. They will be expected to manage their practices efficiently, collaborate with other members of the health care team and use community resources to enhance the effectiveness of services to children and their families.

The ambulatory experience responds to these needs by developing skills in counseling, anticipatory guidance, developmental appraisal, referral, consultation, use of screening procedures and practice management. Skills relating to the care of children with chronic illnesses and handicapping conditions are particularly important. Finally, the ability to coordinate services, plan comprehensive care and mobilize available

community resources is essential to provide ambulatory care of high quality. To accomplish all this, there remains a distinct need for faculty development and greater support for research related to ambulatory care. Full-time faculty members in ambulatory pediatrics need formal training in the discipline; it is no longer acceptable to assume that any pediatrician can teach ambulatory pediatrics.

Unfortunately, the pediatric community finds itself in the unenviable position of responding to a dramatic shift in educational need in an atmosphere of fiscal restraint. Moreover, increasingly larger percentages of medical school funds are being devoted to the delivery of patient care, a development which we recognize is a justified response to the public demand for quality health but one which means that other sources of support are necessary if service programs in educational centers are to improve the teaching environment--particularly through the development of model ambulatory care programs. An appropriate program of grants for general pediatric training could respond to this need by earmarking funds for the development of ambulatory pediatric models. We would reiterate, also, that the Academy does not seek additional pediatric residency positions but, rather, the means to improve the quality of existing residency training and provide the necessary redirection of content.

The relative availability of funds for research and training in the sixties promoted the growth of subspecialization. The influence of these subspecialties and of the service funds associated with them was an important factor in bringing about emphasis on residency training in inpatient settings at the expense of training in ambulatory care. Traditionally, departments of surgery and medicine, as compared to departments of pediatrics, have received disproportionate levels of hospital and medical school support because of the revenue generated from their hospitalized patients. Lower rates of hospitalization and greater volume of ambulatory care have been contributing factors to under-support of pediatric departments.

The need for federal support of ambulatory training programs derives also from the present pattern of reimbursement for pediatric services by third party payors. The funds used to support pediatric residencies are pooled from many sources including Medicaid, other patient-care revenues, state appropriations and grants. Current reimbursement formulas directly and indirectly detract from the importance of ambulatory care and diminish pediatric department operating budgets by imposing restrictions on full reimbursement for ambulatory care. Medicaid reimburses well below the actual cost of providing ambulatory care in a teaching setting, and many private insurance policies do not cover ambulatory care. Sixty-five per cent of families have no insurance covering office visits to a physician. Furthermore, procedure-dominated reimbursement systems tend to discriminate against the provision of preventive services, which constitute a large proportion of good pediatric practice. Simply stated, pediatric residency programs cannot further expand into ambulatory teaching without independent support. Only separate and dedicated federal funding can accomplish this teaching and training objective.

We believe increased financial support channeled into faculty salaries to be the most effective use of increased funding. Current circumstances find medical school faculty commonly forced to "earn their keep" by delivering medical care during non-teaching hours. This obviously detracts from teaching time and effectiveness. In the pediatric field, this problem is compounded by the generally longer hours required of practicing pediatricians and the above-mentioned disproportionate financial stress on pediatric departments. A more substantial federal support program would free pediatricians on medical school faculties to do their job, namely, to teach pediatrics to the best of their ability.

As the emphasis on teaching ambulatory care increases, pediatric departments will need to cope with the serious shortages of faculty to teach in such areas as adolescent medicine, learning disabilities, care of the chronically ill, ambulatory care, community pediatrics and the behavioral sciences. Faculty development in these areas will require financial support for fellowship and research positions in these disciplines. This means that pediatric education, which is already costly, will grow even more so if it responds to the obvious health needs of our nation's children. In the past we have been much slower to finance ambulatory and preventive care than catastrophic or tertiary care. However, it is increasingly clear that economical and effective health care depends much more on the former than the latter. We ask you to recognize this situation in this and future health manpower funding proposals.

Finally, the American Academy of Pediatrics would like to offer its services to aid in implementing some of the suggestions made above.



Ambulatory Pediatric Association

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19 March 1981

Statement for the Record

The Ambulatory Pediatric Association, a national organization of over 1300 physicians and other health care providers interested in the provision and quality of care delivered to the nation's children, strongly urges the continuation of current levels of funding for the training of primary care physicians. Primary care practice is that type of care that provides ongoing access, coordination of care, prevention, and continuity of care to the people of this country regardless of the types of problems they may have. In contrast to specialist care, primary care deals with all of the health and medical needs of people, and the primary care practitioner makes referrals for consultation and care only when the problem's complexity requires the service of a specialist. Because the United States, in contrast to many other countries, has allowed an unrestrained increase in the number of specialists, the number of primary care practitioners declined until the federal government encouraged their training within the last decade. Despite statements that "specialists provide primary care," this is not the case. Specialists only provide certain aspects of primary care, but they do not take responsibility for the patient's overall care over time or for coordinating various aspects of the patient's care. Moreover, their fees for visits are higher than the fees charged by pediatricians and generalists, and they do not provide as easy access to care as these primary care physicians. Very recent data collected by several PSRO's indicate that a major reason for longer length of stay in hospital (and, hence, costs of care) on the East coast as compared with the West coast are a result of the fact that primary care doctors predominate in the care of hospitalized patients on the West coast whereas it is specialists who do so in the East. A recent study in the city of Baltimore examined the balance between primary care physicians and specialists and demonstrated that specialists do not provide primary care. The myth that an adequate supply of physicians overall will lead to adequate primary care can only aggravate the situation with regard to control of costs and make it more difficult for patients to obtain care when they need it.

Because the national trend was towards specialist care rather than primary care for several decades up to the most recent one, the support of primary care training by the federal government is critical. It is only very recently that primary care training has begun to be a legitimate aspiration for medical students, particularly those in the

better medical schools where virtually no such physicians were trained for many years. Faculty in primary care are in extremely short supply because of the historical trends, and government funding of training programs has served to attract individuals into the teaching of primary care. Without continuation of support, the training programs will not survive, and we will revert to the trends that previously held. GMENAC projections of an adequate supply of primary care physicians are based upon continuation of output at current levels. If training programs are discontinued, the supply will fall precipitously. This is because trainees will transfer to specialties where their training is subsidized by research dollars as well as by continued high levels of reimbursement for specialist care, as such care is more often covered by third party payers than is the case for much of primary care.

We, therefore, strongly urge rejection of the proposed cutbacks in funding for primary care training as consistent with the efforts to fight inflation and emphasize preventive health care.

Testimony of

THE AMERICAN COLLEGE OF CARDIOLOGY

Submitted by

Dr. Dan McNamara, President

Mr. Chairman and Members of the Committee:

I am Dr. Dan G. McNamara, Professor of Pediatrics and Chief of the Cardiology Section, Baylor College of Medicine and Texas Childrens Hospital in Houston. I am also President of the American College of Cardiology, a professional medical specialty society of more than 11,000 physicians, scientists, and educators who specialize in diseases of the heart and circulatory system. It is in this latter capacity that I submit this testimony for inclusion in the formal hearing record.

Extension of Operating Authorities of Health Manpower Programs

We have carefully reviewed H.R. 2004, "The Health Professions Educational Assistance and Nurse Training Amendments of 1981". This Committee is to be commended for so expeditiously considering legislation to extend the expiring legal operating authorities of Federal health manpower programs. By and large, we support H.R. 2004's provisions regarding institutional support, construction assistance, student assistance, and project grants support.

Provisions Related to Medical Training for Foreign Medical Graduates

During the 96th Congress, the House Commerce Committee reported out legislation (H.R. 7204) which would have increased the allowable duration of stay for a foreign medical graduate in an accredited medical residency training program from the current maximum of three years to a period of time equal to the normal period of prescribed residency training or seven years, whichever is less. The legislation also provided for flexibility in

enabling a foreign medical graduate to alter his designated training program once.

Similar legislation, H.R. 2056, has been introduced by Congressman Rodino and is pending before the House Judiciary Committee. We recommend that this Subcommittee incorporate these important provisions of H.R. 2056 into "The Health Professions Educational Assistance and Nurse Training Amendments of 1981".
Graduate Medical Education National Advisory Committee

We must express our studied opposition to the enactment of Title IV, which establishes by statute the Graduate Medical Education National Advisory Committee (GMENAC).

Less than six months ago, GMENAC, which had been chartered administratively in 1976, issued its final Report. The Report included over 100 complex recommendations regarding physician supply and requirements, geographic distribution, specialty distribution, health financing, health professions educational programs, and non-physician health care providers -- many of which have far-reaching implications for the practice of medicine, the education of health providers, and the quality of care delivered to the American people. The original purpose for the chartering of GMENAC was to provide a core of information, projections, and recommendations upon which policy could be formulated by the Congress and the Executive Branch.

To date, we are unaware that either the Administration or Congress has carefully or comprehensively scrutinized, or decided for or against implementing, the recommendations embodied in the final GMENAC Report. Until such time as this rigorous examination

has been conducted -- an examination which should include the aggressive solicitation of the views of a multitude of professional medical organizations -- we are not convinced that another Federal advisory council is required or indeed even helpful.

This Subcommittee is well aware that, in general, the complex mathematical models utilized to project physician supply and requirements are tenuous at best. In particular, the methodologies utilized by GMENAC have been criticized by many components of the health care community. For example, the College, in testimony presented before GMENAC itself by Dr. Walter Abelmann, M.D., F.A.C.C. has expressed its concern with the reliability of the methodologies, the adequacy of the sampling of experts, the representativeness of the sample, and the bias of the sample for projections for cardiology manpower during the next decade. A copy of this statement is attached for inclusion in the formal hearing record.

The College concludes that GMENAC's Cardiology Manpower Modeling Panel's current recommendations with regard to Cardiology Manpower and Training may result in a significant shortfall of cardiologists and a serious lowering of the quality of cardiovascular care in this country for many years to come.

The College has constituted an Ad Hoc Committee on Cardiology Manpower, chaired by Dr. Abelmann, to continue to examine this important issue and to provide advice and information to this Subcommittee and to the Department of Health and Human Services as health manpower policy is formulated during the next year or two.

Accordingly, the American College of Cardiology recommends that Title IV, regarding the statutory establishment of a Graduate Medical Education National Advisory Committee, be deleted from H.R. 2004.

Thank you for providing the American College of Cardiology with an opportunity to present our views.

COMMENTS ON THE JULY 12, 1980 RECOMMENDATIONS OF THE
INTERNAL MEDICINE SUBSPECIALTY - CARDIOLOGY
MODELING PANEL TO THE GRADUATE MEDICAL EDUCATION
NATIONAL ADVISORY COMMITTEE (GMENAC)

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INDEX

	<u>Page</u>
I. Introduction	1
II. General Comment	2
III. Comments on the Use of the Delphi Method	3
IV. Critique of Assessment of Current Needs for Cardiologists' Services and of Current Activities of Cardiologists	4
V. Critique of Projected Manpower Needs	5
VI. Comments with regard to Cardiology Training Programs	6
VII. Conclusion	7
References	8

I. INTRODUCTION ,

Thank you for allowing me to make this presentation on behalf of the American College of Cardiology, of which I am a Trustee. The American College of Cardiology is a non-profit association of some 9,000 physicians in the field of cardiology, comprising practicing cardiologists, cardiovascular surgeons, teachers of cardiovascular science and medicine, and clinical as well as basic science investigators. One of the principal objectives of the College is the support of optimal detection, treatment, rehabilitation and prevention of cardiovascular disease, in other words maintenance of cardiovascular health. Another mission of the College is the continuing education in cardiovascular sciences and medicine, not only of its members, but of all cardiologists, internists and primary care physicians responsible for the cardiovascular health of their patients.

The American College of Cardiology has a long standing and ongoing interest in questions of Cardiology Manpower, dating back to an in-depth Cardiology Manpower Study completed in 1973 (1). This study was subsequently summarized, and some of its implications were discussed (2). It also led to a Bethesda Conference on Cardiology, co-sponsored by the College (3).

Being thus aware of the inherent difficulties and pitfalls of manpower studies, and especially of projections of manpower needs, the College wishes to compliment the Graduate Medical Educational National Advisory Committee (GMENAC) on the courage, dedication and thoroughness with which it is pursuing its task. We are grateful for the opportunity which we have had over the past three weeks, with the assistance of Dr. Robert Mendenhall and his staff

at the University of Southern California, to review some of the data, tabulations and calculations of GMENAC as they pertain to Cardiology Manpower assessment and projections. We appreciate the courtesies extended to us by the GMENAC staff, by members of the Battelle Institute in Seattle, and by one of the panelists who worked on the initial identification of needs. I would be less than candid, however, if I did not express the College's disappointment and deep concern that, in contrast with other Specialty Societies, it was not given an earlier opportunity to share its knowledge and expertise with the Committee.

In this presentation I shall outline the College's first reaction to the Cardiology Modeling Panel's recommendations and take up some of our concerns about the validity of certain aspects of the data and projections. The College has every intention to follow up on this preliminary response, take a hard look at the full data base and projections developed by GMENAC, and make its own evaluations and projections available within a reasonable period of time.

II. GENERAL COMMENT

The recommendations of the Cardiology Modeling Panel of July 12, 1980, of a need for only 7,500 - 8,000 cardiologists in 1990 clearly carries the unstated implication that the 9,400 cardiologists active in the United States in 1980 are an excessive number, and the assumptions that the population of the United States will either decrease or decrease in age, or require fewer cardiologists' services, or change its behaviour markedly from the present pattern of a self-referral rate for cardiologists' ambulatory services in excess of 60% and for hospital admissions to cardiologists' care of 30% (4). We are not aware of any national resolve to effect such changes by the year

1990. On the contrary, ours is an aging population, whose morbidity from cardiovascular disease is most likely to increase as the cardiovascular mortality decreases (5). Furthermore, we are greatly concerned about populations cardiologically underserved, especially in rural areas and in the East South Central and West North Central regions of the United States (1).

III. COMMENTS ON THE USE OF THE DELPHI METHOD

The Delphi Method, which was developed over 25 years ago at the Rand Corporation, is a valuable method of arriving at consensus about long-range forecasting as an aid to planning. This method underlies the Bethesda Conferences, introduced by the College in 1966. In its traditional form, the method consists of sending a questionnaire to a group of experts, making a synthesis of their anonymous replies, and recirculating this synthesis for further consideration, repeatedly if necessary (6). The strength of this method of predicting future developments lies in the selection of a broad sample of experts, and the opportunities for anonymous expression of views as well as for interchange of views and ideas.

In the case of the Cardiology Modeling Panel, serious questions may be raised as to the adequacy of the sample of experts, the representativeness of the sample, and hence possible bias of the sample. On most of the issues, the views expressed by the two or three participants were identical. Thus one may even question whether the method used still qualifies as a Delphi or even consensus method.

IV. CRITIQUE OF ASSESSMENT OF CURRENT NEEDS FOR CARDIOLOGISTS' SERVICES AND OF CURRENT ACTIVITIES OF CARDIOLOGISTS

Presumed disease incidence data were derived from the National Household Interview Survey and the National Hospital Discharge Study, both of which have serious limitations. The ambulatory visit data derived from the former are based exclusively on the conditions selected, on interviews of laymen, and only one member of each household was queried about the family. True incidence and prevalence of cardiovascular disease and needs for cardiovascular medical services are not revealed in this manner.

For utilization data, GMENAC draws upon the National Ambulatory Medical Care Survey (NAMCS) and upon the Hospital Discharge Study. The NAMCS considers only office-based practitioners and their office visits; visits to out-patient departments, clinics and emergency rooms, which account for about 7% of cardiologists' work, are not considered (4). The care provided by the 36% of institutional cardiologists is not included. Furthermore, diagnostic and therapeutic procedures are not identified in this data base. Limitations of the Hospital Discharge Data include the failure to identify specialists who participated in care, nor do they consider all consultative and referral practices of cardiologists.

The current data base does not make optimal use of Mendenhall's objective 1976 Cardiology Practice Study (4). This study yields a factor of 1.5% for patients under 17 years, three times the rate used in the GMENAC Model. This study's diary method indicates that 31% of cardiologists' Ambulatory Practice and not 10%, is comprised of non-cardiovascular services, including 5% directed to subjects judged healthy. Finally, the Mendenhall Study

reveals that 25% of cardiologists' time is devoted to teaching and research, and another 5% to administration, activities not fully accounted for in GMENAC's modeling.

V. CRITIQUE OF PROJECTED MANPOWER NEEDS

The most serious omissions from GMENAC's projections for Cardiology manpower needs, potentially catastrophic for the nation's health, are the needs for teaching, research and administration, incidentally taken into full consideration in several other specialties.

In addition to present needs--incompletely reflected in current utilization assessments (V.6.)--a number of factors which may considerably increase future needs must be considered. If increased numbers of primary care physicians, including internists, as well as nurse practitioners and physician assistants, are to be taught and trained in cardiovascular science and medicine, the needs for cardiology teachers will increase. Undergraduate, graduate and post-graduate teaching, as well as increasingly mandated continuing education, must be included in the projections. Attention must also be given to the increasingly appreciated shortfall in cardiovascular researchers, especially with regard to clinical investigators (7).

The last few years have been characterized by major new developments in cardiovascular diagnosis, treatment, rehabilitation and prevention, both primary and secondary (5,8,9). These have brought with them rapidly developing areas of sub-specialization, many still expanding. One need only mention echocardiography, nuclear imaging, applied exercise physiology and rehabilitation, behavioral cardiology, coronary by-pass surgery and the accompanying

advances in intensive care. Further developments in cardiology are likely and have been predicted (6). Not only must we provide for cardiology manpower to deliver these services, but also for manpower to clinically investigate, evaluate and teach these developments.

Finally, as mentioned earlier, the decrease in cardiovascular mortality may be predicted to result in increasing cardiovascular morbidity of the increasingly older survivors. Thus, it would seem most desirable to consider age and sex differences, along with regional differences, in the modeling work. Whereas age-specific characteristics of the population may change only moderately from 1980 to 1990, these changes are expected to be traumatic during the last decade of the century (10).

VI. COMMENTS WITH REGARD TO CARDIOLOGY TRAINING PROGRAMS

It is the understanding of the American College of Cardiology that the Advisory Committee is recommending a 20% reduction in currently available adult cardiology fellowship training positions. The College must express its concern and reservations relative to this recommendation. First, the preliminary review by the College indicates that more, not fewer, cardiologists will be needed in 1990, as compared to 1980. Second, until there is a national mandate through legislation or regulation that would change the current method of referral or self-referral practices, there should be no mandated changes made in the number of available first year positions. And third, it should be recognized that the Liaison Council on Graduate Medical Education (LCGME) is about to begin a long-awaited accreditation process of the sub-specialty programs of internal medicine, including adult cardiology. The College welcomes this approach to quality control. It is anticipated that

there will be some decrease in the number of programs which will qualify. Any efforts to mandate a national cut-back should await the implementation of this accreditation process to determine its effect upon the total number of available cardiologists. This process will surely have some of the leveling influence which your Committee is recommending in terms of the growth of the profession by 1990.

VII. CONCLUSION

In conclusion, it is the considered opinion of the American College of Cardiology that GMENAC's Cardiology Manpower Modeling Panel's current recommendations with regard to Cardiology Manpower and Training will result in a significant shortfall of cardiologists and a serious lowering of the quality of cardiovascular care in this country for many years to come.

The College expresses its sincere hope that the Cardiology Modeling Panel will reconsider its recommendations in the light of this presentation.

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**AMERICAN HOSPITAL ASSOCIATION**

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INTERNATIONAL HOSPITAL PROGRAM

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE SUBCOMMITTEE ON HEALTH
AND THE ENVIRONMENT
OF THE
HOUSE COMMITTEE ON ENERGY AND COMMERCE
ON NURSING EDUCATION AND
FOREIGN MEDICAL GRADUATE PROPOSALS

March 26, 1981

The American Hospital Association, which represents over 6,100 member hospitals and health care institutions, as well as more than 30,000 personal members, is pleased to have this opportunity to present its views on nursing education and foreign medical graduate (FMG) proposals under consideration by this Subcommittee.

The AHA has chosen to limit its remarks to the nursing and FMG issues, as a result of an Association policy decision to cooperate with administration and congressional efforts to reduce the federal budget and yet provide federal financial assistance to programs most necessary to the well-being of the American people. As a principal employer of health care professionals, the hospital industry is committed to ensuring an adequate supply of all such professionals. However, it is imperative that, during these times of limited federal dollars, Congress focus on issues of national priority. From the AHA's perspective, even though there are many health manpower programs that it would like to see funded, nursing education stands out as a national priority.

NURSING EDUCATION

Hospital Efforts

The AHA has singled out the nursing issue as one of the most important to the 6,100 hospitals which comprise its membership. Of these, 344 conduct educational programs to prepare students for professional nursing, 249 of which form an AHA membership group, the Assembly of Hospital Schools of Nursing. Many hospitals also contribute significantly to the education of nurses in both basic and advanced educational programs by serving as clinical facilities for the practical components of such programs.

Moreover, hospitals are the major employers of nurses. A 1977 HEW-funded study revealed that more than 61 percent of the nation's practicing registered nurses (RNs) were employed in the hospital setting. It is clear that, despite alternative delivery systems and other employment opportunities, the majority of today's nurses work in hospitals.

Hospitals have begun to address the problems of nursing shortages in a constructive manner and are attempting to develop innovative solutions. At a recent AHA nurse recruitment and retention workshop, hospital representatives shared with each other some of their new strategies, among them:

- St. Joseph's Hospital, Stockton, California: Day-care services for children of hospital employees.
- Valley Presbyterian Hospital, Van Nuys, California: Tuition reimbursement and inservice educational programs for all shifts.
- Good Samaritan Hospital, Portland, Oregon: Night shifts of nine hours

for four nights per week, allowing nurses three nights off; availability of shifts if additional salary is needed.

- Bay General Community Hospital, Chula Vista, California: Career ladder approach, allowing clinical nurses to advance by meeting certain non-academic requirements (e.g., projects previously outlined in a career ladder manual).
- Conemough Valley Memorial Hospital, Johnstown, Pennsylvania: 100 percent tuition reimbursement for university credits towards a Bachelor of Science in nursing (BSN), up to six credits per term; a 180-hour optional refresher course for nurses wishing to work at the hospital; and continuing education units for nursing employees who attend courses, accredited by the National Association of Critical Care Nurses, in regional intensive and critical care.
- Rapid City Regional Hospital, Inc., Rapid City, South Dakota: RN pool under which nurses sign up for days, shifts, and services they wish to work; attend a two- to three-week orientation program if needed; and work at least three shifts per month.

Many hospitals have undertaken education and training programs designed to assist nursing service administrators in their management roles. Hospitals also have applied management engineering techniques to the problems of nurse scheduling. In some institutions, computer-assisted nurse scheduling systems have maximized the ability of their administrations to apply nursing resources most productively, accommodate shift preferences, and minimize scheduling conflicts.

In addition, the AHA has recently initiated a National Commission on Nursing, which is an autonomous forum of national leaders in the fields of nursing,

hospital management, medicine, government, academia, and business.

The commission is composed of 30 commissioners serving as either individual members or representatives of organizations. Among the individual members are prominent hospital administrators, nurses, physicians, academicians, and executives from health-care-related businesses and groups.

The health-related organizations which have representatives on the commission are the American Association of Colleges of Nursing, American Hospital Association, American Medical Association, American Nurses' Association (ANA), American Society for Nursing Service Administrators, Assembly of Hospital Schools of Nursing, National Council of Hospital Governing Boards, National League for Nursing (NLN), and the Division of Nursing of the Department of Health and Human Services (HHS).

The commission is the first joint effort of its kind to address national nursing issues and is designed to be responsive to the needs of nurses, physicians, hospital administrators, and legislators. It has been chartered for a three-year period.

The commission has three interrelated and overlapping activities: collecting data and information, formulating recommendations, and developing practical action plans.

One of the commission's major tools for collecting data and information has been a series of public hearings held across the country. The public hearings provide opportunities for a broad range of individuals and organizations at the grass-roots level to aid in identifying and defining problems and issues. Other

data collection methods include reviewing current literature and existing studies and collecting reports of ongoing programs and projects that are designed to improve nursing and nursing practice.

Data and information gathered by the commission will be used to formulate recommendations that reflect a consensus of the commission members. The recommendations will lead to the development of action plans that will provide practical solutions for institutions and organizations confronting nursing problems. Action plans could include such activities as demonstration projects and various publications. The emphasis in any action plan developed by the commission, however, will be on practicality and usefulness.

The Nursing Shortage

Hospitals are sincerely committed to the delivery of high quality, cost-effective health care services to the patients they serve. However, in order to accomplish this mission, there must be an adequate supply of highly qualified health professionals to meet the staffing requirements of our nation's health care institutions. While there are aggregate increases in the total supply of health professionals, in certain fields, especially in nursing, hospitals are experiencing severe and chronic shortages. AHA-member hospitals indicate that they have between 90,000 and 100,000 nursing vacancies, and 80 percent of the nation's hospitals are said to have unfilled nursing positions.

Recent information from state hospital associations confirm this data. For example:

- In May 1980, the number of overall RN vacancies in South Carolina

consisted of 771.5 full-time equivalents (FTEs), with large counties, essentially urban in nature, reporting vacancies of 626.5, and rural counties, of 307.4. The number of licensed practical nurse (LPN) vacancies was reported to be 307.4 FTE. In addition, 16.4 percent of all RN positions were vacant, as were 15 percent of all LPN positions.

- In October 1980, the Indiana Hospital Association reported that the vacancy rate for nurses in Indiana hospitals was 11 percent for 1980, 2.6 percent higher than the previous year, despite a 9.1 percent increase in nurse employment. Overall the nurse shortage is more severe in large urban areas. The Gary area has the highest vacancy rate in the state, at 22 percent, followed by the Indianapolis area at 15.2 percent. Hospitals in Indianapolis and its adjoining counties hired 550 more RNs in 1980 than in 1979, but were still short by 653 nurses. Evansville area hospitals reported a vacancy rate of 9.8 percent, 1.2 percentage points below the statewide figure, while the Fort Wayne area's vacancy rate was 4.7 percent. The lower vacancy rates in the Evansville and Fort Wayne areas can be partially attributed to the presence of four of Indiana's six hospital-based diploma schools of nursing.

Shortages of nurses are also more severe in larger hospitals, with those having more than 150 beds reporting a vacancy rate of 12.5 percent, compared to a 5.3 percent rate in those with fewer than 150 beds.

- In March 1980, the Ohio Hospital Association reported that, of 15,249 full-time budgeted RN staff nurse positions in Ohio, 1,512 or 10

percent were vacant. Of the 7,248 part-time budgeted RN staff positions, 932 or 12.9 percent were vacant.

- In July 1980, the North Carolina Hospital Association reported that North Carolina needed 1,300 additional full-time RNs, 522 additional full-time LPNs, 198 part-time RNs, and 108 part-time LPNs.
- In February 1980, the Maryland Hospital Association report that Maryland's community hospitals were experiencing a 14 percent shortage and an approximate 29 percent annual job turnover rate among RNs and LPNs. The specific turnover rate for RNs was 32 percent and for LPNs, 27 percent.
- In September 1980, the Illinois Hospital Association reported 4,982 vacant RN staff positions (13.4 percent) and 1,365 vacant LPN staff positions (12.1 percent) in Illinois. Regional data indicates that the city of Chicago has the highest vacancy rate in the state.
- In May 1980, the Florida Hospital Association reported 2,520 vacant RN positions and 904 vacant LPN positions in Florida.
- In 1979, data indicated that California had a 17 percent vacancy rate for full-time nursing positions in hospitals, while Texas reported that more than 12 percent of positions were unfilled.
- Georgia reported that one in eight full-time budgeted positions in the state's hospitals were vacant, and yet there were over 500 vacancies in the state's schools of nursing this academic year.
- Pennsylvania indicated 1,550 budgeted vacancies in hospitals throughout the state.

According to the Department of Labor's Bureau of Labor Statistics of job openings in the health care field in the 1980s up to 50 percent will be for nurses--approximately 83,000 annual openings for RNs. The ANA cites higher figures,

predicting that, by 1982, there will be a nationwide shortage of 100,000 nurses.

Hospitals are not only concerned about the present shortage, but also about the future availability of nursing personnel. Even though job opportunities abound, not enough people are going into nursing. The number of graduating nurses declined 2 percent in 1979--the first time in 10 years that fewer nurses were graduated than the year before--according to data from the NLN. The league also reports that applications for RN programs dropped 16 percent between 1977 and 1978. With the rate of unemployment for nurses--also 2 percent--remaining far below the norms for other categories of comparable professionals, the league predicts that the current nursing shortage will become even worse in the near future.

A report of the AHA's Advisory Panel on the Nurse Shortage explains that the problem exists not only in regions, states, and counties, but also within single facilities. Many hospitals reporting unfilled budgeted positions indicate greater difficulty in recruiting for evening and night shifts and for particular units: intensive, coronary, psychiatric, and geriatric care.

The factors underlying the shortage of professional nurses in hospitals are numerous and diverse. Nursing must compete with a variety of other career opportunities which have become increasingly available in recent years. Even in the profession of nursing, nurses have the opportunity for greater diversification--into industrial health, health promotion, community health centers, and clinics, for example--which have provided the profession with greater opportunities for mobility and career advancement as well as more convenient work hours.

Compounding the problem is the trend toward shorter lengths of stay by more

acutely ill patients requiring more technologically complex nursing care. The creation of intensive-care units and specialized services within hospitals has resulted in an increased demand for RNs, as have changes in the utilization patterns of hospitals, with shorter stays reflecting a greater focus on the planning of admissions and discharges and a greater use of outpatient facilities.

ANA data reflect this demand, showing that hospitals have hired increasing numbers of RNs in the past few years to handle such units and services.

The effectiveness of such special-care units will be severely compromised if sufficient numbers of well-trained hospital nurses are not available. The pressures felt by hospital nurses are compounded by the trend to a more medically intensive hospital caseload. The demands on nurses are not simply physical and mental, but their emotional resources are called upon as well. Their ability to meet many demands is taxed by prolonged understaffing, in situations in which hospitals are unable to recruit nurses. Hospitals are, therefore, concerned that a persistently inadequate supply will compound the existing problem by further discouraging active nurses and increasing the potential for what has been called "burnout."

Not the least of the AHA's concerns are the cost implications of staff turnover, recruitment, and replacement. For each nurse who leaves, the National Association of Nurse Recruiters estimates that a hospital spends from \$150 to \$4,000, with an average of \$1,000, to recruit a replacement. Hospitals unable to obtain permanent staff have often responded to nursing shortages by using nurse registries--services that provide pools of temporary nursing personnel. In response to a survey conducted by the AHA in January 1979, 35 state hospital associations reported that member institutions have become increasingly reliant on temporary

nurses for their nursing departments. On a national average, each hospital in the United States recruited 140 RNs in 1980.

The shortage of professional nurses will have serious consequences for the physical well-being of the growing elderly population. Although representing only 11 percent of the current population, Americans over 65 account for 23 percent of hospital discharges and 35 percent of total hospital days, and experience 50 percent longer lengths-of-stay and comparatively higher surgery usage.

Since the turn of the century, great strides have been made toward increasing the longevity of Americans. Life expectancy has been extended from 48 years in 1900 to 73 years currently.

According to HHS, the 65-and-older group is the fastest growing segment of the American population. By the year 2039, there will be more than 50 million Americans 65 years or older--an estimated 17 percent of the total population in that year. This sharp rise in the number of older Americans will have a dramatic effect on utilization of hospital and nursing home care. Projected trends for short-stay hospital days of care, reported by the National Center for Health Statistics Hospital Discharge Survey, show that during the next 25 years, total days per year will increase from 36 to 47 percent, with 12 to 20 percent of the increase due to the aging of the population.

The provision of health care for the older-age group will, of necessity, be shared among all health professionals within the delivery system; however, the greatest responsibility will undoubtedly fall to nurses, who must attend to patients' daily needs. Hence, there is likely to be an even greater need for

pecially trained nurses to meet the unique medical requirements of the elderly, whose demands for restorative, maintenance, and palliative care are greater than those of the general population. For example, four out of five older persons have at least one chronic disease. Of the 81 percent who have chronic conditions, 46 percent experience activity limitations, with 40 percent limited in major activities. Moreover, the assessment and implementation of appropriate plans of care for elderly patients are more difficult because a variety of physiological and psychosocial factors must be taken into consideration. Such factors deepen the severity of the nursing shortage.

Guidelines for Federal Support

In view of the current and projected nursing shortage, the AHA believes that federal support for nursing education should continue. However, the authorization levels for nursing programs should be determined by Congress and the administration, after careful consideration of all the priorities in the health budget. Consequently, while addressing the FMG issue, the AHA is focusing its comments on H.R.2004, the present proposal before this subcommittee, on the importance of certain programs under Title III, Nurse Training. In our opinion, the priorities for funding should be (1) student assistance, (2) special project grants, (3) advanced nurse training programs, and (4) institutional support. The general principles governing such support should include (1) emphasis in program support on those nursing curricula that provide for articulation among nursing programs, thereby offering career ladders to those in diploma and associate degree programs; (2) encouragement of entry into the nursing profession at a time when other fields are presenting competitive challenges to more traditional women's occupations, such as nursing; and (3) equitable distribution among the

three types of basic nursing education curriculum and between basic and advanced nursing programs.

Student Assistance

The AHA believes that scholarship and student loan programs should be continued in order to assist students who may otherwise not be able to complete their educations. The Association supports the objective of the Chairman to increase the number of minority health professionals by maintaining the scholarship program for disadvantaged students. An analysis of federal student assistance for Fiscal Year 1974 showed that 20 percent of nursing scholarships were awarded to black students, a proportion in excess of the 2.5 percent of black nurses in active practice. The most recent figures from the NLN show a decrease in enrollments for both minority and male students in basic nursing programs. Cessation of scholarship funding would certainly reinforce this trend.

Scholarships have been awarded in schools of nursing to those in greatest financial need; such students are frequently from backgrounds that make it difficult for them to borrow from the private sector. Moreover, such students are not in positions both to support themselves through part-time jobs and, if course requirements dictate, to pursue remedial and supplementary programs to help them graduate successfully.

Data obtained from the HHS publication, "Entry into Nursing, Part II," indicate that the most significant determinants of a student's decision to apply to a particular nursing program are the cost of the program and availability of financial aid. Currently, one in every three applicants asks for financial assistance.

In addition, many nursing schools report to us that up to 80 percent of their student bodies may be dependent on some form of student assistance, with federal funding supplying a significant proportion of that aid. Tuition costs for nursing students also tend to be high in comparison with tuition costs for educational programs in the liberal arts, because there are frequently laboratory fees, costs of transportation to clinical sites, and exceptionally high teacher/student ratios in comparison with other undergraduate programs. The withdrawal of federal student assistance funding would be particularly hard on private nursing schools in states where public funds are available only for state institutions. Therefore, the AHA supports the provision in H.R.2004 which would extend the scholarship and student loan programs.

Special Project Grants

The AHA is pleased that H.R.2004 proposes to extend authority for special project grants. The Association supports the continuation of such grants to increase the supply or improve the distribution by geographic area of adequately trained personnel; to provide more opportunities for disadvantaged or minority nurses; and to improve curricula, including those for pediatric, obstetric, and geriatric nursing.

Special consideration should be given to projects that would (1) promote career articulation for nurses who want to move up the professional ladder; (2) encourage mergers between hospital and collegiate schools of nursing; (3) enhance the clinical training of nursing students, especially through internships/preceptorships and "reality-based" (i.e., 24-hour) experiences, and (4) provide opportunities for nursing faculty to upgrade their clinical skills, especially via short-term traineeships.

Career articulation: Special projects should be designed to encourage career mobility.

One of the major problems that exists today in nursing education is the lack of a standard, articulated career ladder that would enable most nurses to progress from entry level up to the highest level through a recognized hierarchy of steps. In fact, a direct educational career ladder does exist for some nurses who enter the system by earning a baccalaureate degree in nursing (BSN), are then qualified to enter a master's program leading to a nursing degree, and progress to a doctoral degree in nursing. However, because the vast majority of practicing nurses today, and the majority of nurses entering the profession in any given year, do not hold a baccalaureate degree, they are excluded from immediate access to advanced educational opportunities.

For nurses who wish to progress through the educational system, the baccalaureate degree is the gateway to advanced programs. A nurse who undertakes basic educational preparation for a practical, associate degree, or diploma program lacks such a gateway, in that his or her academic credits generally do not apply towards a baccalaureate degree.

In recent years, with the assistance of the federal government, several models have been developed for an integrated career structure to obviate the difficulties experienced by individuals with various degree credentials trying to pursue better positions on the career ladder. The concept of career articulation was well-identified by the National Commission on Nursing and Nursing Education, which stated: "Every nurse should be provided with continuing opportunities for career mobility, specifically including the right to extended formal education, with a minimum of obstacles and a maximum of choice."

In 1970, the NLN published a statement on the open curriculum in nursing education, which led to the development of a federally funded open curriculum study. The open curriculum was defined as "an educational concept that promotes institutional practices that capitalize on students' individual backgrounds, needs, and abilities." It considers "prior relevant education and experience,...may provide for either upward or lateral movement or both,...offers flexibility of exit from, and entry or re-entry into a program,...and may employ such nontraditional educational practices as self-pacing, work/study, or credit by examination."

This evaluation study was published in 1979 and documents survey research on programs and students involved with open curriculum practices. It indicates that time, money, and motivated people are needed to develop an open curriculum and that "more elaborate and imaginative projects require special funds."

Federal funding of special project grants designed to promote career articulation would have the following benefits:

- (1) Nurses seeking higher education would be qualified to move through the system in an orderly way.
- (2) All previous educational experiences in nursing would earn academic credit.
- (3) Employing institutions would have a more highly qualified work pool available to them and a staff potentially more able to satisfy their individual career aspirations.
- (4) Public and private funding for nursing education would be more effectively utilized if earned credits were transferable among programs.
- (5) Both individual nurses and employers would benefit if uniform ex-

pectations and skills were adopted for each level of education within a single system.

Mergers between hospitals and collegiate schools of nursing: Special project grant money should be used where appropriate to encourage hospital-based schools of nursing to merge with collegiate schools of nursing. It is our belief that, where cooperative arrangements exist to facilitate the integration of new professionals into the work place, the retention of such professionals is higher. Such systems include joint appointments for clinical nurses as academic faculty members, supervised preceptorship and internship programs, and other such formal relationships between academic and service institutions to help close the widely identified gap between the education and service programs.

An example of a recent merger is York Hospital with York College of Pennsylvania. The hospital had operated a school of nursing for over 80 years but, with the rising costs of nursing education and a keen awareness of changing patterns in nursing education, recently found it appropriate to enter into merger negotiations with the college nearby. The two institutions had been affiliated for several years and arranged for the college to provide general education courses for the nursing school. A joint committee of the two institutions, which had some overlapping trustee memberships, worked to develop a collegiate program to provide nurse manpower for the hospital, educate nurses for work at the bedside, introduce a baccalaureate degree program that was both generic and a BSN completion program for RNs, and formulate a long-range plan for an associate degree nursing program that might possibly articulate with the BSN program.

The practical arrangements for this merger were undertaken by a number of li-

aision committees, with the presidents of the two institutions having ultimate decision-making authority. The hospital committed money to the college to underwrite the program costs in the initial phases and, in return, the college granted the hospital participation rights in curriculum planning for both components. The college also received federal funding to help in curriculum development.

Recent mergers have shown the following benefits:

- (1) The values and particular virtues of the hospital school are maintained.
- (2) Students in schools that have merged with academic institutions are more easily accorded credit for general education coursework and for nursing courses.
- (3) The frustrations of RNs seeking to enter higher education levels are avoided.
- (4) The hospital that continues to serve as a site for clinical instruction potentially has the chance to recruit for its own labor force from among the students of the program.

Clinical training: The AHA supports increased federal assistance for clinical education in both basic and advanced nurse training programs. Furthermore, the Association stresses the importance of upgrading the clinical parts of the basic education curriculum for those nurses who will enter the secondary and tertiary care systems, since the majority of nurses are employed in institutional, and not in primary care, practices. Reports from many hospitals indicate that numerous basic nursing education progrms do not provide sufficient emphasis on clinical training, which must then be provided on the job. Exposure to such

training may also motivate students to choose the hospital setting as a work environment upon completion of their basic programs. Moreover, because of the increase in technology and the development of special-care units, clinical training is essential at the advanced level to prepare nurses to meet the challenges of specialized nursing in the hospital setting.

Advanced Nurse Training

The AHA continues to support advanced nurse training programs which provide funding for three major categories: preparation of nursing faculty, the quality of whom has a direct effect on the quality of care given by students to patients; managerial education for supervisory and administrative nurses, most of whom presently rely on the on-the-job training; and advanced training in specialty areas. Programs for training nursing administrators are particularly important, due to the general belief that a lack of nursing service administrators, combined with the sometimes inadequate management training of many nurses serving in administrative capacities, has contributed to the growing dissatisfaction and subsequent shortage of nurses.

Advanced nurse training programs should be offered on a part-time, as well as a full-time, basis, since many prospective enrollees must continue to work to meet personal financial needs.

Advanced nurse training funds can encourage the development of innovative work/study programs. For example, a program developed jointly by the AHA and the University of Illinois School of Nursing could be replicated in other places with advanced nurse training funds. The program enables practicing nursing

service administrators to combine their continuing work experiences with alternating residential sessions, featuring self-learning modules supplemented by a local preceptor's instruction. Such a program, adopted nationwide, would help meet the urgent need for more formally educated management nurses in hospitals. Such courses should be credit-carrying to enable students to attain degree status by consolidating coursework.

Institutional Support

Should federal support for capitation grants to schools of nursing be continued, the AHA urges that the support be provided to all three basic nursing programs: diploma, associate degree, and baccalaureate degree. Nursing schools are dependent on capitation funds for general support, which is vital if they are to help meet the increasing demand for more hospital-based nurses and more nurses to fill positions in alternative settings. They also are dependent on such funds for enlargement of faculties, of which there is currently a serious shortage. Without such funds, the shortage would be aggravated, resulting in cutbacks in these educational programs.

Congress may wish to provide capitation on an incentive award basis, rewarding those schools that help meet national priorities, such as increased enrollment of disadvantaged students.

FOREIGN MEDICAL GRADUATES

H.R.2056, introduced by Rep. Peter Rodino (D-NJ), and pending before this Subcommittee for consideration, would extend the "substantial disruption" waiver provision of Section 212 of the Immigration and Nationality Act to December 31,

1983. Existing law permits teaching hospitals to request a waiver of certain provisions of the act (which limit the participation of FMGs in U.S. graduate medical education programs) if it is shown that exclusion of an alien medical graduate from the program would cause a substantial disruption in the health services provided by the hospital. Under current law, this waiver expires December 31, 1981.

The AHA strongly supports this proposed extension, but recommends that the provision be extended until December 31, 1984, to allow for an orderly phaseout of the program. The availability of this waiver is critical to certain major urban health institutions. As you know, many hospitals, both public and private, are experiencing severe financial difficulties as a result of the volume of uncompensated services provided to urban residents lacking health insurance or eligibility for public programs. A significant side-effect of this problem is the decreased ability of such hospitals to retain medical staff and to maintain graduate medical education programs. As financial conditions worsen, salaries in these hospitals cannot keep pace, and the ability of the institutions to maintain the equipment and support services required by physicians in specialty practices becomes severely limited.

Recent data show that there has been a steady decline in the number of FMGs since 1977: as of November 3, 1975, 7505; as of June 30, 1976, 7450; as of January 10, 1977, 5090; as of January 10, 1978, 3531; as of January 10, 1979, 2578; and as of January 10, 1980, 2000.

A statistical summary of positions in U.S. graduate medical education programs is provided in Attachment 1. A comparison of those positions with the summary statistics in Attachment 2, which lists the number of waiver requests and ap-

provals by specialty, reveals that most of the waiver approvals were for specialty programs that experienced the greatest shortage of residents (in raw numbers and not necessarily by percentage of total positions); the most obvious exception is the family practice specialty, which had 659 vacant positions but which received only two waivers.

Substantial disruption waivers are analyzed by state in Attachment 3, showing that most waivers (282 positions) were granted to New York. New Jersey, which received 22 waived positions, was a distant second.

The AHA also supports the provision in H.R.2056 which would extend the length of time FMGs may spend in the United States for training from the existing two years to seven years. The proposed change would recognize that many postgraduate programs require more than two years to complete.

CONCLUSION

The American Hospital Association appreciates this opportunity to present its views on the nursing and FMG issues being considered by the Subcommittee and would be pleased to provide any further information or assistance that may be requested.

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Attachment 1

STATISTICAL SUMMARY OF RESIDENCY POSITIONS BY SPECIALTY

SPECIALTY	# Positions 1979-80	# Residents on Duty 9/1/79	# Vacant Positions	% Vacant Positions
Allergy/Immunology	154	155	0	0
*Anesthesiology	2,799	2,491	308	11%
Colon and Rectal Surgery	44	42	2	4%
Dermatology	797	801	0	0
Dermatopathology	16	19	0	0
*Family Practice	7,011	6,352	659	9%
*Internal Medicine	17,074	16,580	494	3%
*Neurological Surgery	596	579	17	3%
*Neurology	1,323	1,212	111	8%
Nuclear Medicine	219	174	45	20%
*Obstetrics/Gynecology	4,705	4,496	209	4%
*Ophthalmology	1,532	1,538	0	0
Orthopedic Surgery	2,563	2,572	0	0
Otolaryngology	1,079	1,038	41	4%
*Pathology	2,819	2,519	300	11%
Blood Banking	29	21	8	3%
Forensic Pathology	42	24	18	43%
Neuropathology	62	52	10	16%
*Pediatrics	5,639	5,603	36	1%
Pediatric Allergy	65	53	12	5%
Pediatric Cardiology	144	128	16	11%
*Physical Medicine/Rehabil.	507	490	17	3%
Plastic Surgery	422	412	10	3%
Preventive Medicine				
General	237	199	38	16%
Aerospace Medicine	45	25	20	44%
Occupational Medicine	87	70	17	19%
Public Health	29	23	6	21%
*Psychiatry	4,730	3,901	829	17%
Child Psychiatry	695	521	174	25%
Radiology, Diagnostic	3,090	3,069	21	1%
*Radiology, Therapeutic	512	377	135	26%
*Surgery	8,539	7,689	850	10%
Pediatric Surgery	24	37	0	0
Thoracic Surgery	285	276	11	4%
*Urology	1,132	1,077	55	5%
TOTAL	69,036	64,615	4,421	6%

Source: '80/'81 Directory of Residency Training Programs
American Medical Association

* Specialties in which waivers have been granted during 1978-80

ALLEGHENY CO.

SPECIALTY	1978			1979			1980			TOTAL #	
	# PRO.	# POS.	# POS.	# PRO.	# POS.	# POS.	# PRO.	# POS.	# POS.	REQUESTED/	APPROVED
Anesthesiology					4	18	3	14	4	23	41/37
Family Practice					1	1	1	1	1	1	2/2
General Practice					2	2	0	0			2/0
Internal Medicine	2	2	0	0	5	18	1	3	8	36	54/33
Neurology	1	1	1	1	2	7	2	7	2	2	10/10
Neurosurgery	1	1	0	0	1	1	1	1			2/1
Obstetrics/Gynecology	1	1	1	1					1	1	2/2
Ophthalmology					1	1	1	1			1/1
Pathology	1	1	1	1	4	6	4	6	6	13	20/18
Pediatrics	7	10	3	4	10	58	7	53	13	102	170/154
Physical Medicine									1	7	7/7
Psychiatry	4	6	3	5	8	16	6	12	17	42	64/55
Radiology	1	2	1	2	2	2	2	2	2	3	7/7
Surgery	6	11	3	4	4	9	3	8	5	25	45/36
Urology									1	1	1/0
TOTAL	24	35	13	18	44	139	31	108	61	254	428/363

PRO. = number of programs

POS. = number of positions

STATISTICAL SUMMARY OF WAIVER REQUESTS AND APPROVALS BY SPECIALTY

STATISTICAL SUMMARY OF WAIVER REQUESTS AND APPROVALS BY STATE

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HOS. = number of hospitals
PRO. = number of programs
POS. = number of positions



association of american medical colleges

Statement of the
Association of American Medical Colleges
on
The Health Professions Educational
Assistance & Nurse Training Amendments of 1981
(H.R. 2004)
and
A Bill to Amend the Immigration & Nationality Act
(H.R. 2056)

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to share with the Subcommittee its views on H.R. 2004, The Health Professions Educational Assistance & Nurse Training Amendments of 1981, and H.R. 2056, legislation related to issues concerning alien graduates of foreign medical schools. The interest of the Association in this legislation is self-evident. Since its founding in 1876, the AAMC has steadily expanded its horizons so that today it represents the whole complex of individual organizations and institutions charged with the undergraduate and graduate education of physicians. It serves as the national voice for the 126 U.S. accredited medical schools and their students; more than 400 of the major teaching hospitals; and over 70 academic and professional societies whose members are engaged on an everyday basis in the activities---teaching, research and patient care---that in the aggregate constitute medical education.

Submitted to the House Committee on Energy & Commerce, Subcommittee on Health & the Environment. March 20, 1981.

JUSTIFICATION OF FEDERAL ROLE IN
MEDICAL EDUCATION

Prior to outlining its specific program recommendations, the AAMC believes it is necessary to outline its views on the support of medical education.

In reviewing recent developments, the AAMC has been impressed with the need for and justifiability of marshalling support for medical education from all of its beneficiaries. It is easy to see how students benefit, in that education provides them entree into a well remunerated profession. Indeed there are those who would place the entire burden of the cost of the education on the student. However, with these costs probably currently averaging in excess of \$20,000/annum per student, exclusive of living expenses, this option is not generally viable.

The extraordinary commitments of the states to medical education indicate the recognition of the importance of medical schools to them. In academic year 78-79, state support of public medical schools totaled \$1004¹/₂ million and these jurisdictions provided an additional \$79 million to private schools; these amounts account for about 38% of the total operating revenues of the nation's medical schools. The states have borne and are bearing an unusually large share of the responsibility for financing medical education.

Now, as in the past, the schools stake their claim on Federal resources on the fact that they are a national resource, engaged to a significant degree in public service activities that impact on the whole nation and thus merit Federal subsidy. At this time, the country is currently extremely sensitive to, and deeply engaged in, an examination of the economic constraints within which this nation can operate, both domestically and abroad. Central to this exercise is an intense scrutiny of the entire spectrum of

program which realistically deserve Federal support. Thus, the following points need to be made in support of the schools' claim that Federal resources are warranted:

- The health needs of citizens throughout the country are served by a system of medical education that uniformly produces highly competent physicians, based on national standards and thus warranting national support.
- The high degree of geographic mobility of physicians imbues them with the character of a national, rather than local, resource and justifies Federal subsidization of the schools which provide their education.
- Medical education requires subsidy because it is far more expensive than other graduate or professional education programs, and is, in practical terms, beyond the economic reach of many able, altruistic and well motivated students.
- The Federal Government entered into a partnership with medical schools to achieve commonly agreed upon public purposes, the accomplishment and maintenance of which require continuing mutual commitment.
- Fulfillment of specific legal entitlement commitments by the Federal Government to the citizenry depend upon the availability of competent physicians in adequate numbers.
- Medical schools, engaged in myriad education, research and patient care activities, all of which contribute to the betterment of the nation's health and response to Federal initiatives, require flexible funds to maintain their capacity to respond to national needs related to the pressing medical and social problems such as improving and expanding access to health care and advancing biomedical knowledge.

SPECIFIC PROGRAM RECOMMENDATIONSStudent AssistanceRationale for AAMC Position

Prior to addressing the specifics of the student aid proposals advanced by H.R. 2004, it is necessary to outline the basic rationale upon which the Association's views on the future of student aid is predicated:

- In view of their future high income potential, all but the most impoverished students and their families should ultimately bear primary responsibility for financing a significant portion of their medical education through direct payment, loan repayment or service payback.
- The cost of obtaining a medical education is becoming almost prohibitive for the average individual. Tuitions have increased dramatically over the past decade. In private schools, the average first-year tuition has increased from \$1,050 in academic year 1960-1961 to \$7,910. Over this same epoch, the median first year tuitions in public schools have grown from \$498 for residents to \$2,070 and from \$830 to \$4,118 for non-residents. Without a reasonably comprehensive set of aid programs, the opportunity to secure an M.D. degree will be limited to only those fortunate enough to occupy the upper economic levels of our society---those who are more accustomed to the notion of investing large sums for a future return.

- The period of training required to become an adequately educated physician is long and arduous, usually encompassing a span of no less than 7 and often several more years.
- The medical school curriculum is so rigorous and demanding as to make outside employment to defray expenses virtually impossible during most phases.
- Medical students who finance their education through borrowing are faced with the prospects of high and rapidly rising debts. The average debt of students with indebtedness who graduated in 1980 was \$17,200.

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- The future of other forms of aid upon which medical students have traditionally relied is now increasingly in doubt, particularly in light of the Administration's proposals to cut the very valuable Guaranteed Student Loan (GSL) Program. In academic year 1979-1980, 35,183 medical students (55.1% of all students) received aid under this program, which provided 70.5% of all loans to medical students.

Criteria for student

A careful analysis of the above factors, in light of the prevailing economic climate, has led the Association to conclude

that student assistance is its highest priority and most urgent recommendation in the development of new authorizing legislation. It is imperative that the Congress enact into law an appropriately balanced portfolio of programs designed to meet the needs of all qualified students seeking access to a medical education regardless of economic status. Such a structure should encompass: scholarships for the most impoverished students; subsidized loans for students with substantial needs; and market rate loans for the financially able.

The characteristics to be built into these programs obviously merit careful attention. Perhaps the most important is the assurance of availability of assistance. The enormous difficulties and uncertainties that have ensued due to oscillations in the availability of student aid in the last year are very undesirable and worked severe hardships on the students and the schools. The recent ups and downs of the HEAL Program, described elsewhere in this statement, are illustrative of this point. Once students have gained acceptance into medical school, they should be able to pursue their education with reasonable certainty that assistance will be available until graduation. Several other criteria are intrinsic to a well designed and cost effective assistance structure. The Association maintains that future student aid programs should reflect the lessons of past experience and thus should:

- Establish manageable debt repayment options in recognition of the economic reality that initiation of repayment of loans is virtually impossible during undergraduate and graduate medical education and may be a serious hardship during the very early years of practice, when incomes are often economically marginal.

- Award assistance on the basis of need, at the discretion of the financial aid officer at each medical school. It is imperative, particularly during the current economic climate, that the limited financial resources available be distributed in the most cost-effective manner. Given the diversity of individual needs and circumstances and the complexities of the various aid programs, the school financial aid officer is the most qualified individual to make these determinations.
- Expand opportunities for students to repay their indebtedness through loan forgiveness. The present provision for loan forgiveness has been oversubscribed. In academic year 1979-1980, 76% of all graduating medical students reported indebtedness. Moreover, the percentage of all graduating students with debt in excess of \$20,000 increased from 18% in 1978 to 30% in 1980 and the percentage of students with debts above \$30,000 increased from 6 to 10% during this time frame. The Association believes that service as a means of repayment will become attractive and even a necessary alternative to many students as their level of indebtedness increases. Thus, loan forgiveness becomes a viable option, as well as highly

advantageous to the Federal Government in that the latter need only invest in exactly the numbers and types of personnel it needs when it offers this option for fulfilling a specified Federal need rather than 5-7 years earlier, when future needs are hard to discern. This mechanism has the added advantage of not forcing students to make premature career choices of specialty.

The Association must weigh student aid proposals in light of their potential to meet these important criteria.

Student Aid Provisions of H.R. 2004

The Association is gratified to note that many elements of the student aid programs envisioned by the proposal before this Subcommittee adhere to the principles discussed above. Moreover, the AAMC is particularly pleased that, since this bill basically retains the assistance structure extant in current law, efforts have been made to address those aspects of these programs that experientially have proven to be troublesome.

Outlined below are views on the specific programs which would be authorized under H.R. 2004.

Health Education Assistance Loans (HEAL) Program

H.R. 2004 proposes to retain the Health Education Assistance Loan (HEAL) Program established under P.L. 94-484. The problems that have arisen in the implementation of this program are well-known to this subcommittee. Last fall, the Program collapsed due to the decision of the major active lenders to withdraw their participation because of what they regarded as an inequitably low interest rate in light of rapidly escalating market rates. In an

effort to revive the program and to eliminate other problems that had arisen in its implementation, Congress passed legislation (P.L. 96-538), which:

- Eliminated the 12% interest ceiling under current law and substituted a floating interest rate that the lenders agreed would be satisfactory---the average bond equivalent of a 91-day Treasury bill plus 3.5%.
- Removed the restriction precluding HEAL borrowers from also borrowing under the Guaranteed Student Loan (GSL) Program in the same academic year.

Since passage of this statute, banks have resumed their participation in this program, but further modifications are needed, and H.R. 2004 attempts to address them. The Association supports the provisions to enhance the flexibility, usefulness, and accessibility of these loan funds: by increasing the potential annual and aggregate borrowing limits to \$20,000 and \$80,000 respectively; and, by removing the remaining eligibility restriction on HEAL borrowers---the stipulation that no more than 50% of each school's students can receive HEAL loans.

The Association views the HEAL Program at this time as one of last resort, because of the enormous indebtedness that current interest rates presage. Assuming that the loan was negotiated on a fixed rate basis, a student borrowing \$10,000 a year or \$40,000 aggregate under current market rates of approximately 18%, would be liable to repay a total of \$188,860 over the minimum ten year repayment period or \$1,574 per month for 120 months. H.R. 2004 proposes revisions that could, at least in part assuage this burden.

While the Association is supportive of these modifications, it urges that the Subcommittee make further efforts to lessen the costly repayment requirements that fall upon HEAL borrowers, by:

- Extending the deferral of repayment until completion of periods of national service and graduate medical education. The Association believes that this would:
 - facilitate better debt management by permitting borrowers to defer repayment until they are in a more realistic economic position to do so. Several residency programs now demand periods of training of five or more years.
 - act to reduce disincentives for young physicians to serve in shortage areas.
 - not lead to a significant increase in the Government's expenditures for this programs. Since HEAL is not a Federally subsidized program, the costs to the Government of such an improvement would be minimal.

The high debt burden that a student could incur under this Program has highly undesirable economic and social consequences. High levels of indebtedness:

- May be a strong disincentive for physicians to enter practice in primary care in rural and inner-city areas where they are most needed because these practice modes and areas are less likely to produce the necessary income to repay these debts.

- Could have a chilling effect upon the choice of medicine as a career by minority and financially disadvantaged students.
- Will probably result in additional "pass through" costs to the consumer.

The AAMC believes that these potential problems merit serious attention by the Congress and would strongly recommend that in modifying the loan consolidation provisions of the Higher Education Act, that some mechanism be established to alleviate the interest burden of medical students with debt levels in excess of \$25,000.

Health Professions Student Loan (HPSL) Program

The Association is gratified that H.R. 2004 proposes the retention of the HPSL program, which has been highly successful in channeling aid to students based on an accurate assessment of their needs and thereby increasing the access of needy students to health professional careers. The 1978 Report of the AAMC Task Force on Student Financing found that the HPSL program was an important factor in minimizing the debt burden on economically disadvantaged students.

Moreover, the Association believes that several of the features embodied in the HPSL Program have combined to establish it as a particularly cost-effective aid mechanism from the perspective of all parties concerned---the students, the schools and the Federal Government. This program:

- Permits aid to a substantial number of students who are in exceptional need but are unable to secure

awards under the Exceptional Financial Need (EFN) Scholarship Program---for one reason or another, i.e., are not in their first year of school---but are not financially able to assume burdensome HEAL loans. For academic years 1978-1979 and 1979-1980 respectively, awards to 9,808 and 7,646 medical students were made under this program.

- Recognizes the unique needs of and the range of economic circumstances presented by each student by providing financial aid officers with the flexibility necessary, to assemble student aid packages to fit individual requirements.
- Authorizes funds received in repayment of loans by past borrowers to be utilized for new loans to needy students. While this program is still young and repayments are just beginning to approach steady state conditions, its reauthorization will eventuate in at least a partially self-sustaining, cost-effective means of financing aid to needy students that is sound from both an economic and public policy perspective.
- Provides a partial loan forgiveness option that serves as an effective device to attract physicians to underserved areas.

The Association believes that this program will continue, as in the past, to meet a very important student aid need; without it many students who meet the stringent need criterion for this program ---the possession of resources that do not exceed the lesser of \$5,000 or one-half the costs of attending school---would have had

no alternatives other than to accept the repayment burden under the HEAL program or a service commitment under either the NHSC or the Armed Forces Scholarship programs.

Exceptional Financial Need (EFN) Scholarship Program

The AAMC believes that the high costs involved in training physicians mandate, as a matter of public policy, that specific provisions be made to insure that even the most economically disadvantaged students not be denied access to a health professions career for financial reasons. Therefore, the Association strongly endorses the retention of the EFN Scholarship program envisioned by H.R. 2004. This program has enabled the medical schools to admit a more socioeconomically heterogeneous cohort of students and has helped to limit the degree to which access to a career in medicine has become a privilege of only the more affluent.

Under current law, only first year students in exceptional financial need qualify for this program. Recipients receive tuition, fees and a modest living stipend; no service obligation is incurred. While this program has been praised in concept, its implementation has drawn criticism. The 1978 Report of the AAMC Task Force on Student Financing pointed out that: the definition of exceptional financial need "as zero financial resources is unreasonably restrictive; scholarship support for only one year is inadequate and should be expanded to two years; and appropriations for the program have been inadequate." For academic year 1979-1980, only enough funds were allocated to make 340 such awards to medical schools. The Association is pleased to note that the need criterion was finally revised this past summer by regulation and that H.R. 2004 seeks to address the remaining problems by: extending eligibility

for this program to second year students; and expanding the program's authorization levels.

National Health Service Corps (NHSC) Program

The AAMC---a longstanding advocate of the NHSC as an effective and socially desirable instrument to improve the specialty and geographic distribution of physicians---has become progressively more concerned that the costs of this Program will drain large amounts of funding from the increasingly scarce resources available for other vital programs. There has been a growing conviction that the NHSC has become an unnecessarily expensive solution to the maldistribution problems in the Nation. There has also been concern that these problems no longer demand efforts as strenuous as in the past. These assertions should not be interpreted to mean that the AAMC believes that the Federal Government has no responsibility to assist in correcting the maldistribution of health professionals or indeed that maldistribution problems no longer exist. Rather, it is an expression of the Association's concern that the Corps, in its present form, does not appear to be the most cost-effective mechanism through which to address these problems and that in light of the amelioration of these problems---in part attributable to the NHSC---the magnitude of current needs now merits reevaluation. For these reasons, the Association believes that the Subcommittee should not permit further growth of the Corps, advocated by H.R.2004, pending a reassessment of the country's needs and the exploration of less costly means of meeting them. The Association would suggest that the Subcommittee consider expanding the popular loan forgiveness provision in the Health Professions Student Loan Program---which has been

oversubscribed---to all Federal loans. Funding such a program at a modest level would provide the opportunity to test the viability of loan forgiveness in current economic circumstances, as a less expensive complement or alternative to the National Health Service Corps Program.

The Association supports the revisions proposed by H.R. 2004 to promote greater cost-effectiveness in the Corps, particularly those designed to encourage expanded use of the program's private practice option. H.R. 2004 also proposes to alleviate the direct cost of the Corps by creating a third category of service in which the individual does not become an employee of the U.S. Government; the entities to which this category of physicians would be assigned would be responsible for assuring salaries for these Corps members commensurate with those of other Corps employees. This measure might be at least one means of scaling down the growing costs of the Corps.

Finally, the bill also proposes several other revisions which the Association believes might prove useful in increasing the overall effectiveness of the Corps particularly those designed to: improve the assignment of Corps personnel and establish a revolving fund in the U.S. Treasury for the purposes of carrying out the operation of the Corps Program.

National Health Service Corps (NHSC) Scholarship Program

Consonant with the view that the Corps Service Program has grown too costly, the AAMC believes that its feeder mechanism, the Scholarship Program, should be scaled down accordingly. In academic year 1979-1980, medical students received approximately \$49.8 million

in NHSC Scholarships---more than half of the funds appropriated. Thus, it has proven to be a substantial form of student aid and the impact of the loss of these funds must be considered. Therefore, restoration of funds in this amount through some other form or forms such as more generous authorizations for the HPSL Program and other aid programs is vital to the continuation of adequate student assistance.

In addition, the AAMC would like to take this opportunity to note that H.R. 2004 proposes several revisions to the Scholarship Program which the Association believes are particularly desirable:

- Require the Secretary to give special consideration to applicants who: intend to become primary care physicians in shortage areas; have resided or been employed in such areas; or meet other qualifications which may assist in determining if an individual will become a primary care physician in such an area. The AAMC believes that this stipulation would help insure that the applicants most genuinely committed to the goals of the Program would benefit from the award of these scholarships.
- Specify that individuals who are both National Research Service Award (NRSA) and NHSC Scholarship recipients may count their service in the NRSA Program against their obligated time in the NHSC. The Association believes that this would serve as a useful and necessary clarification of current HHS policy which now permits only scholarship recipients who receive individual NRSA's to accrue such credit. H.R. 2004 would extend such credit to institutional NRSA recipients as well.

Institutional Support

A variety of cogent arguments may be advanced to justify general Federal support to the institutions engaged in medical education. They add up to the position that the Federal Government, as an important beneficiary of the process, both in its own right and as an agent for the general public, should assume its fair share of the unusually costly process. The Congress appears to have shared this conviction in 1971 and at that time requested the Institute of Medicine (IOM) to assess the true costs of medical education and to recommend what would constitute a fair share for the Federal Government to underwrite. The report of the carefully crafted IOM study concluded that an appropriate Federal share would be about a third of the education program costs. The Association found the IOM study well documented and persuasively argued at the time of its publication, and can identify nothing that has subsequently happened to invalidate the arguments or reduce the force of the conclusions. A GAO Report in 1978 found institutional support was used effectively and for some institutions was critical to their fiscal stability.

The clear trends in public policy on this issue since the publication of the IOM Report have been to specify in even greater detail what a school must do to receive a progressively dwindling award. The per capita grant was \$2065 in FY 1972, while this year's---barring rescissions---will be about \$315 in 1972 dollars. Meanwhile educational costs have nearly doubled. This is the Federal contribution to the support of institutions that, partially in response to Federal programs have doubled enrollments, mounted (with or without special project grant support) educational programs in primary care medicine, expanded minority enrollments, and undertaken a host of other public interest activities.

This very minimal Government investment in these institutions has clearly yielded a high return in immediate and long range public benefits and has confirmed the value of these institutions as instruments of change in our society. The Federal Government's small, but vital contribution to the maintenance of these institutions which serve as major agents of innovation in this country should not be abandoned.

Potential Loss of Institutional Support

While currently computed on the basis of student population---considered at one time to be the most equitable formula for allocating these funds among eligible institutions---institutional support is not primarily a form of student subsidy. Rather, these funds are utilized for the stabilization of an institution's entire education program, through discretionary interventions at appropriate times and places. Institutional support, small as it is, is the only accessible uncommitted money available to many schools. The true value of these funds exceeds by far their actual magnitude. Most medical school deans view them as the most useful at their disposal: the only resource of funds to meet unexpected contingencies and emergencies, and to develop the new and innovative programs the nation so desperately needs to advance the health of our people.

The schools have made commitments to educational programs that hew to joint Federal/institutional objectives, perhaps of higher priority to the former than the latter. Cooperation with government on these public-interest ventures is costly to the schools. For example, the sponsor does not pay the full costs of the programs and contributes not a whit to the cost of faculty

time and effort involved in the planning of these programs, the development of new curriculums, the preparations and processing of applications, etc. Discretionary funds are critically needed: to meet unmet institutional costs to the schools of joining hands with government in a wide variety of activities of great benefit to the whole nation; and especially, to deal with the turbulence induced by vacillations and oscillations in federal commitments.

There is a prevalent misperception that student financial assistance funds are essentially fungible with flexible institutional support: schools can redeem the loss of these funds by raising tuition, an option made viable by the fact that students have access to loans or scholarships. This argument has very limited validity. Private schools have the freedom to increase tuition at whatever frequency and to whatever extent they desire. Tuitions in many private schools are already staggering. The result is that the social/economic/cultural/ethnic mix of the student body becomes a less representative and more elitist cross section of America. For most public schools tuition increases are not a viable option. Changing tuition is complicated, time consuming and cumbersome, often requires action by a Governor, a Legislature (which may meet only biannually), a Board of Regents or a State Commission on Higher Education. The result of an increase is variable: in some states, tuition is returned to the State Treasury, deposited either a general or a dedicated account (e.g., for retirement of construction indebtedness); in others, the increased revenue from tuition can and often will be offset by an equivalent decline in appropriated funds. Thus, the use of student aid to

compensate for the loss of the funds proposed

by H.R. 2004 is not, in the Association's opinion, a viable option. As noted elsewhere, the States are already contributing heavily to the costs of medical education; imposing a further burden upon them would probably not be feasible or fair. Accordingly, the Association is persuaded that the Federal Government should continue to discharge its responsibility for providing the schools with a form of flexible institutional support.

The integrity of a large number of medical schools is seriously threatened today by plethora of destabilizing fiscal forces, whose cumulative impacts could be lethal, an outcome, surely not in the public interest. Medical schools and affiliated teaching hospitals will, in the next few years, be faced with unprecedented reduction in revenues on several fronts---from service programs and in terms of constant dollars from severe cuts in research and research training funds. The anticipated reduction in the biomedical research budget, alone, poses extremely difficult problems for the schools, as large numbers of faculty are partially supported by Federal research dollars and divide their time and compensation between education and research. The economic reality is that some form of institutional support is now more necessary than ever to maintain the innovation, creativity, integrity and very viability of these institutions that have done so much to propel the United States to its position of preeminence in medicine and biomedical and behavioral research.

The potential impact of the termination of institutional support envisioned by this proposal must be viewed in the context of: almost certain reductions in revenues; the impact of inflation;

and increased costs to the schools in complying with a host of government regulations. The Subcommittee's acceptance or rejection of the proposition advanced by H.R. 2004 must be a carefully weighed decision and one which is fully cognizant of the potential implications of such an action.

Conditions of Support. While reluctantly recognizing the inevitability of conditions for participation, the Association believes that any such condition must meet two criteria to be acceptable: that it be compatible with, and not violative of, the essential nature of the institution requesting support; and, that it reflect sound public policy. The first criterion would require that the condition imposed be germane to the purpose and function of the institution as historically and legally constituted, fall within the scope of the activities over which the institution has control, respect the institution's academic traditions, and constitute a true flexible institutional subsidy, not simply cost---or less than cost---reimbursement to carry out a Federally mandated specific task. For instance, medical schools have limited powers to influence specialty and geographic distribution of physicians; to demand of them what is not feasible would be ineffective and unfair. The second criterion would guarantee that the schools be required to accept only conditions leading to outcomes generally recognized as highly desirable national goals. The expansion of undergraduate medical school enrollments to avert a critical shortage of physicians was subject to almost unanimous agreement throughout the country a decade ago, and thus reflected sound public policy at that time. But events have so greatly changed the present realities that further enrollment

increases may lead to physician oversupply and an enrollment decrease may be needed in the not too distant future.

Finally, it seems important to register one additional demurrer related to the increasing specificity of the terms which schools must accept as preconditions for receiving Federal institutional support. This protest arises not out of any desire to evade work or to get a free ride, but out of a deep conviction that this government's posture is self-defeating, even though it may give the appearance of responsible stewardship of public funds. The schools have a capacity to do far more than narrowly conceived tasks that have matured to the stage of being reducible to legislative language. They represent a perennial resource of imaginative ideas for the resolution of societal problems. Their faculties are usually far ahead of other segments of society in recognizing problems and in taking "fliers" at their solution. What the government should seek, if it really wants to exploit this treasure of talent, is a way to keep the attention of academic faculty focused on as wide as possible a spectrum of both mature and inchoate problems.

Special Project Grant Program

Special project grants complement in very important ways the other mechanisms for Federal assistance to medical education. Under this rubric, solutions to specific societal problems can be sought through what are really cost reimbursement contracts between the Government and institutions possessed of the resources to implement the project. These grants offer schools modest incentives to undertake a wide variety of innovative educational activities that the Federal Government views as having high priority in terms of the public interest.

The great virtue of these grant programs is that they can cover an extremely broad range of objectives and are ideal for capitalizing to the maximum on the rich diversity represented among the schools. However, special project awards seldom really reflect full costs. Without the availability of some other Federal subsidy, such as institutional support, the schools are forced to subsidize these projects from their extremely scarce resources.

The Association is heartened that H.R. 2004 reauthorizes many of the genres of activities initiated under P.L. 94-484 embracing a comprehensive list of projects currently of national concern. The Association would like to take this opportunity to:

- Endorse the renewal authority for project grants for residencies in family medicine and Departments of Family Medicine. However, the Association would like to urge that the authorization level for training grants be expanded. The growing popularity of Family

Medicine as a specialty is a hopeful sign that the primary care health care needs of the Nation will be better served in the near future. Family medicine is at a critical stage of development---new programs must be designed; existing programs improved; curriculum developed; facilities constructed or renovated; teachers recruited or trained. These programs have been highly effective in developing primary care professionals and sufficient funds are urgently needed to maintain momentum.

- Support the reauthorization of training programs in general internal medicine and general pediatrics. Moreover, the AAMC believes that the expansion of this authority to include grants for the training of physicians who teach in these programs and to also provide assistance to these individuals in the form of traineeships and fellowships would fill an outstanding need. The Association urges the Subcommittee to consider increasing the funding levels for this program. However strong the Congressional and public desires to hold down federal spending wherever possible, reduction of the authorization ceilings of programs that have been successful in ameliorating the problems of specialty maldistribution of physicians is self-defeating. If the aggregate special project authorization ceiling cannot be increased, the Association would much prefer reductions in authorizations for programs whose success is not yet evident.

- Concur in the proposed revisions to the Area Health Education Center (AHEC) Program which would: permit AHEC programs which have previously received initial development support to continue to receive modest funding for the purpose of continuing or initiating projects designed to improve health manpower distribution; and, clarify the relationship of AHECs to the National Health Service Corps.
- Advocate the retention of project grants for educational assistance to individuals from disadvantaged backgrounds and the expansion of this authority to include the establishment of a variety of programs such as work study, enrichment and retention programs and joint initiatives between college and health professions institutions. This important grant authority has been invaluable in encouraging the application of minority and low income students to medical schools and has allowed 65 institutions to develop projects of this type since the program's inception. Moreover, in the period from 1972-1980, twice as many minority students were admitted to medical schools receiving support under this program than to institutions not participating in this program.

Finally, while the overall catalogue of special projects listed in this bill reflects a comprehensive view of activities currently in the public interest, the Association would suggest the possibility of including projects that would address the need to encourage young physicians, particularly minorities, to consider academic teaching careers.

Construction

P.L. 94-484 extended the existing grant program of assistance for construction and renovation of teaching facilities and authorized a new program to assist in the construction of ambulatory primary care teaching facilities. These programs were designed to achieve the dual goal of expanding enrollment and encouraging the teaching of primary care. In recognition of the growing perception that the stimulation of enrollment increases is no longer necessary or desirable, H.R. 2004 proposes to: repeal the enrollment increase requirement in the existing construction grant program; and relieve previous construction grant recipients of their obligations to increase their enrollments. The Association views these as timely modifications that represent sound public policy.

In addition, this bill proposes substantial revisions in construction authorities. It would: eliminate all new construction grant authority, with an exception for two year schools endeavoring to convert to four year facilities; and provide loan guarantees only for the "remodeling, renovating, or alterations" of existing teaching facilities. The Association questions the wisdom of completely eliminating construction grant authority for existing schools. Many existing educational "plants" are clearly in need of replacement---a need which is sure to grow; and, an already serious need exists for ambulatory teaching facilities in primary care. The Association strongly recommends that the Subcommittee accord these problems a more thorough assessment.

Financial Distress

The Association is pleased to note that H.R. 2004 proposes to continue a program designed to assist medical schools in financial distress and that it establishes a separate authority for this purpose. The Association believes that this authority is essential to the continued viability of our country's predominantly minority institutions and probably for an increasing number of non-minority schools which will experience fiscal problems with cutbacks in other support programs.

The Association is particularly heartened that H.R. 2004 deletes the eligibility criteria in current law which requires "appropriate operational, managerial, and financial reforms (as the Secretary may require), including the securing of increased financial support from State or local governmental units" The Association has long opposed this requirement because virtually all of the institutions in severe financial trouble are private minority schools. Since these institutions serve a national constituency, state governments have been very reluctant to come to their aid, as they would for a state controlled institution. Since the institutions in distress have no control over their access to state support, it has been unfair to place this requirement on them.

Predominantly Minority Institutions

There are new as well as established medical schools whose student bodies are comprised predominantly of individuals from minority groups, drawn from all over the country. As private institutions, they have very limited call upon state support and private philanthropy has not met their needs.

Thus, these institutions which meet an important social goal --the education and training of physicians representative of the minority groups in our society--must depend heavily on the Federal Government for support. Most medical schools have made valiant attempts to expand enrollment of underrepresented minorities, but these schools have clearly played an important role in increasing the minority enrollment of first-year medical students from 292 in 1962 to 1,548 in 1980. Our country still has a long way to go before it achieves equality in the health professions. Today, minorities constitute only 9% of the total population of first-year medical school classes. Thus, the AAMC urges the Congress to give sensitive attention to the plight of minorities and the existing minority institutions in formulating new legislation.

Graduate Medical Education National Advisory
Committee (GMENAC)

This bill proposes to establish in statute the recently expired Graduate Medical Education National Advisory Committee (GMENAC). The Association seriously questions the wisdom and the necessity of granting such a committee statutory authority. The staff work used in this Committee's recently issued report should be, and already almost is, a fairly well embedded, function of the Department of Health and Human Services. As long as, and no longer than, Advisory Council review of that staff work is unnecessary, it can be arranged under the administrative authority of the Secretary.

However, the Association feels that an extremely important phenomenon is occurring in the United States at this time as a result of the doubling of the educational capacity of our medical schools and that a major result of this may be a larger influence by market forces on many aspects of medical care, including the geographic and specialty distribution of physicians. An important precondition for the optimal play of market forces is the availability of accurate and timely information. The Association has little confidence in the ability of even the most skilled statisticians using the most sophisticated models and other tools, to forecast with even modest accuracy the future demand for physician services. However, for physicians to make intelligent decisions about career specialization and location of practice, it would be extremely useful if the most current, accurate data related to physician supply and demand, by geographic location and specialty area were available. Information of this character would be useful to correct imperfections in the market mechanisms for distributing physicians.

The Association suggests as an alternative to a statutory GMENAC, that the Government encourage and support better coordination and communication between Federal agencies such as the National Center for Health Statistics and the National Center for Health Service Research and organizations within the private sector concerned with physician manpower research and policy, such as the National Resident Matching Program, the Association of American Medical Colleges, the American Medical Association, the American Hospital Association, the specialty societies, and the specialty boards.

Finally, it must be emphasized that the GMENAC worked for a period of nearly four years to prepare its report to the Secretary. The report has called attention to the notable expansion of the medical education capacity of the country and has alerted us to the possibility of future imbalances in manpower distribution. This contribution has already had an effect on those concerned with medical education and its support.

Alien Foreign Medical School Graduates

H.R. 2056 proposes changes in statutes related to alien foreign medical graduates (FMGs) in, or coming into, the United States for graduate medical education under the student exchange (J-Visa) provisions of the Immigration and Nationality Act. The bill would also amend established laws regarding requirements for permanent residence for non-immigrant alien FMGs currently licensed and practicing in a state.

Duration of Stay

Of the FMG proposals before the Subcommittee, the one to extend the permitted training period to the time typically required to complete a graduate medical education program is the least controversial. Current provisions do not allow residents adequate time to meet the eligibility requirements of many of the medical specialty certifying boards of the American Board of Medical Specialties (ABMS)---requirements that may be assumed to reflect the necessary training period for a designated specialty. Today, training for specialty certification in such areas as obstetrics, dermatology, ophthalmology, radiology, and general surgery all require a duration of graduate education exceeding the maximum of three years now permitted. Under current law, the VQE and language requirements assure the competence of the large majority of alien graduate medical education students. Further, this country has had a long tradition of welcoming exchange students. Extension of the training period is in the best interest of the individual, the program, the individual's country of origin, and the U.S. On that basis, the Association supports the proposal to amend 8 USC § 1182(J)(1)(D) to lengthen the permitted duration of stay.

Further, the Association urges the Subcommittee to amend the effective date of this provision to allow its benefits to be accrued by all alien FMGs currently participating in graduate medical education in this country. As drafted, by limiting the application of the provision to those entering as exchange visitors on or after January 10, 1978, H.R. 2056 would preclude aliens who are now in graduate medical training, under the current extension for a third year of training, from the opportunity to remain in this country to complete programs requiring more than three years of residency experience.

The Association applauds the Subcommittee's proposal to provide a check against possible abuse of the "typical time" provision, by including in the bill a seven-year ceiling on the permitted duration of stay. However, the AAMC fears that the principle behind this limit would be undermined if the further provision---that for exceptions from this seven year limit---were to be interpreted liberally. Even with the understanding that, under H.R. 2056, FMGs would be allowed to change their designated program once, not later than two years after entering for graduate medical training, the Association holds that seven years would be a more than adequate period for the completion of training in almost every specialty. Only four ABMS recognized specialty board certifications require a training period of more than five years (neuro, colon, plastic and thoracic surgery) and only one of these---neurosurgery---requires more than seven years. Consequently, legitimate reasons for needing more than seven years to

complete training are very rare and except for unusual circumstances the seven-year duration of stay would be sufficient. Therefore, the Association recommends that the Subcommittee provide safeguards against possible abuse of the availability of extensions beyond seven years, by including in the bill a provision which requires---as does current law (8 USC § 1182(j)(1)(D)(i))---that: the accredited school arranging or providing the graduate medical training agree in writing to any extension beyond the normally permitted stay; that extensions be at the written request of the alien's country of origin; and that such extensions be solely for the purpose of continuing training in the alien's previously designated program. Further, as generous interpretation would make a mockery of specialty board standards, the Association urges the Committee to include Report language clearly stating that extensions of the seven-year limitation are only to be granted by the Director of the ICA in the most exceptional of cases and after consultation with the Secretary, DHHS.

Substantial Distruption Waiver

The Association is unalterably opposed to any extension of the VQE waiver for substantial distruption. One of the most significant changes to the Immigration and Nationality Act wrought by P.L. 94-484 was the institution of a requirement that FMGs pass the VQE. The purpose of this modification by the Congress in 1976 was to raise the educational achievement standards for FMG entry into the U.S. and to thereby protect the American public from contact with inadequately educated physicians serving as practitioners or hospital residents.

The AAMC recognizes that a few hospitals in this country, particularly in areas such as New York City, are faced with severe problems in recruiting U.S. medical graduates for their residency programs. Nonetheless, if "substantial disruption" waivers are continually granted, these hospitals, which have had more than four years to correct their deficiencies, will postpone confronting the real problem---the quality of the graduate medical education offered and the consequent inability of the program to attract graduates of U.S. medical schools. The AAMC does not take pleasure in appearing to be unsympathetic to the needs of these distressed hospitals; but it is equally distressed by the fact that a substantial segment of the least advantaged American citizens, who live in the affected areas and who depend on these hospitals almost exclusively for their medical care, must rely on physicians who cannot pass an examination so designed that 95% of U.S. medical graduates would be expected to pass.

The proposal to extend availability of substantial disruption waivers implies that the purpose of a residency program is to provide service, ignoring the fact that the fundamental *raison d'etre* of a residency program is educational. Residents are important participants in the American system of medical education. While receiving education, residents at the same time, assist in the training of more junior house staff and, depending on the nature of the hospital's affiliation with a medical school, medical students. The presence of poorly trained upper-level residents can only serve to lower the quality of a program and thus its attractiveness to the graduates of U.S. medical schools. The solution offered by the use of waivers would, thus, only exacerbate the problem.

In the course of their education, residents, by participating in patient care under supervision, do contribute to an institution's provision of care. However, because education is primary, the Association must regard this as an education, not a health care, issue. In this context, it is persuaded that, if the directors of those graduate medical education programs and the medical schools with which they are affiliated were forced to focus attention on the quality of the training programs, the dependence of these programs on FMGs would rapidly diminish.

The Association does recognize that the provision in H.R. 2056 to extend the waiver availability is a modest improvement over the extension provision enacted in P.L. 96-538 in that it requires that before a substantial disruption waiver may be issued, the institution must have a fairly detailed plan for reducing its dependency on alien FMGs. However, in implementing the current law, institutions have already been required to formulate such plans, and this requirement has apparently not been successful in resolving the problem; therefore, the Association does not believe that the change incorporated in H.R. 2056 is of sufficient substance to permit support of the provision.

Conditions on VQE Waiver for Certain Practicing FMGs

By exempting certain practicing FMGs from the VQE requirement, in P.L. 95-83, the Congress acknowledged that the special needs of alien physicians caught in the midst of changing requirements required consideration. H.R. 2056 proposes to further relax the circumstances under which the VQE can be waived by eliminating the specialty board requirement and extending the provisions to those

who were licensed and practicing on January 9, 1978. The significance of this proposal is not clear to the AAMC. As is evident from the Association's opposition to extension of the availability of substantial disruption waivers, the AAMC strongly supports the VQE screen to protect the American public from encounters with alien physicians whose education is not up to U.S. standards. The Association cannot support an amendment to the VQE requirement without first being assured that the important principle behind the requirement---the protection of the public---is not being violated. However, the Association is aware that board certification, a voluntary standard in many states, is only one of several common measures of competency---another being state licensure. Nonetheless, as a condition for waiver of the VQE, the requirement for specialty certification does provide substantial assurance of the competency of the physicians in question.

The proposal to drop this requirement was included in H.R. 7204 during the 96th Congress. The Report of the House Interstate and Foreign Commerce Committee on this Bill (H.Rept. 96-943) indicates the Committee's uneasiness that accurate data was lacking on the number of physicians this provision would affect. The Association shares this concern and believes the Congress has an obligation to the public to obtain this and other data, e.g., regarding distribution, before moving forward with the proposal.

The Association holds that more data is also needed regarding the proposal to extend waivers to alien physicians licensed on January 9, 1978; and it urges the Subcommittee to withhold further action on this matter until clarification of its potential consequences are obtained.

These proposals may represent a reasonable and just accommodation in behalf of a group of individuals caught in a period of transition. However, the need for the changes wrought by P.L. 94-484 have not altered. The Association therefore asks the Subcommittee to use caution in its deliberation on this matter.

Special Immigrant Status

The proposal to provide special immigrant status to alien FMGs who entered prior to January 10, 1977, and were licensed and practicing on January 9, 1978, appears to be designed to insure that certain communities will not lose the services of these practitioners.

The proposal causes the Association serious concern. The individuals in question entered the U.S. with non-immigrant visas and thus with the understanding that they were to return to their countries of origin. This is not the case of individuals caught in a period of legal transition. By voiding their promises to return home and by waiving normal immigration and labor certification requirements, the proposal affords the group exceptional preferential treatment.

The Association does not believe that the health manpower needs of this country are such that this preferential treatment is warranted. Without question there are some communities experiencing health manpower shortages. However, the distribution of physicians is improving and, if predictions of physician oversupply prove correct, will improve at even faster rates in the near future. Further, the proposal is for a class action, and thus would affect alien FMGs all over the nation rather than in selected shortage areas.

Again, adequate information on the numbers and distribution of the involved individuals is not currently available. Consequently, the potential effects of this change are largely speculative. The Association must withhold endorsement of such proposition.

Overall Summary and Conclusions

By introducing H.R. 2004 and H.R. 2056, the House has opened debate on the policy issues fundamental to the future of health manpower. The AAMC has outlined to the Subcommittee the broad policy perspective which it endorses on Federal financial assistance to medical students and to medical education and has evaluated the pending proposals in the light of this perspective. The Association stands ready, willing and able to provide any further assistance to the Subcommittee that is desired.

But in closing, the point should be reiterated that the legislation that finally emerges through the long process of Congressional debate is of critical significance to a set of institutions whose health and well-being is of enormous importance to the nation. During the middle half of the twentieth century, American medical education went from uneven, mediocre and in some cases a totally inadequate standard of performance to a level of outstanding achievement. A glance at the advances in medical sciences during only the past decade gives ample credence to this statement. In the course of this notable rebirth, the health of the nation has benefited considerably and every evidence suggests that the best is yet to come.

The action taken by the Congress on this legislation will have a profound impact on the future of medical education and, through it, on the future health and well-being of our people.

AMERICAN ASSOCIATION OF COLLEGES OF NURSING

I am Sister Rosemary Donley, Chairman of the Governmental Affairs Committee of the American Association of Colleges of Nursing (AACN). The AACN represents 269 Baccalaureate and Higher Degree Programs in Nursing -- the overwhelming majority of programs in collegiate and university schools.

We appreciate the opportunity to support H.R. 2004. In this day of concern with defense spending, inflation and control of the economy, we are pleased that the House of Representatives recognizes the shortage in nursing and the role of the Federal Government in increasing the number of nurses, of facilitating specialized training, and of improving the geographic distribution of nurses.

AACN's major priority is advanced nurse training and traineeships for graduate study. We strongly support these sections of H.R. 2004 because they enhance and enable the preparation of future teachers, administrators of nursing service, clinicians and researchers.

Graduate schools are the sole source of teachers, directors of nursing, researchers and clinical specialists. All levels of educational programs and all service agencies (hospitals, ambulatory and community health centers) depend upon the availability and strength of the graduate programs in nursing. These programs should be expanded and strengthened.

In addition to the nursing shortage which has brought about a crisis in hospital management, there is currently a national shortage of prepared directors of nursing service and faculty in all types of

schools of nursing. Recent discussions and analyses of the nursing shortage in hospitals indicate that staff nurse turnover and failure to recruit and retain nurses are intensified when nursing service departments are disorganized as a consequence of the absence of prepared directors. Hospitals must be staffed by competent nursing service administrators, and nurses must be taught by adequately prepared faculty. We suggest that support for advanced nurse training and graduate fellowships is a most critical role for the Federal Government to play in helping to solve the nurse shortage at the bedside level as well as at the higher education level.

Because of the high priority of the need to facilitate training of teachers and directors of nursing services, more support, rather than less support, is needed for programs of advanced training. Traineeships should also be increased to enable more nurses to complete their graduate study expeditiously.

We also think that loans and grants are essential to enable students to complete a nursing program. Failure to offer loans or scholarships to nursing students weakens recruitment efforts and renders the cost of a clinical education prohibitive for the student and her/his family.

We believe that grants for special projects have enabled schools of nursing to improve educational planning, make nursing education accessible to nurses throughout the United States, improve recruitment and retention of disadvantaged persons, and reduce the cost of instruction through the use of technology.

In summary, the American Association of Colleges of Nursing supports H.R. 2004. Since the Nurse Training Act is the only Federal program available to support the initial and continuing education of nurses, we are concerned that there be a Federal policy for the support of health manpower. However, our more basic interest is in the delivery of health and illness services by nurses. We support the separation of the Nurse Training Amendment from H.R. 2004.

STATEMENT BY THE
FEDERATION OF NURSES AND HEALTH PROFESSIONALS
AFT - AFL-CIO

This testimony represents the policy of the Federation of Nurses and Health Professionals and the American Federation of Teachers, AFL-CIO, an organization of over 550,000 teachers, paraprofessionals, nurses, and allied health professionals, all of whom are directly concerned with the health care services in this country.

The health manpower proposals set forth before this Committee attempt to address an extremely complicated set of problems. The problems of education, distribution, recruitment, retention, and utilization of nurses and other health professionals have become more acute as the cost of providing quality health care service increases. We are all sensitive to the "numbers game" played in Washington last year by the past Administration when funding for nurse education programs was discussed. However, the balance has yet to be struck between potential numbers of nurses needed in the labor market and numbers of nurses actually in practice. The Bureau of Labor Statistics projects that due to the increased growth in and the demand for health care services, there will be a continued requirement for 85,000 new RNs annually through 1990. One statistic which was cited pointed to the fact that in one year alone (1977) the net annual gain for RNs was only 57,000. The current shortage which we all agonize over was not created overnight!! Rather, it seems more realistic to conclude that the current shortage being experienced today has developed over a period of many years.

Reflecting upon all the aforementioned problems and the concerns voiced by our membership, we submit the following summary comments on nurse education funding for your consideration:

Duration and Funding of the Bill

We ask the Committee to consider a five-year funding bill to stabilize funding and to have adequate time to thoroughly research the marketplace, collect and analyze data about the use of funds, distribution and retention of health professionals, and utilization of nurses and other health professionals already in the marketplace. We argue that a major cut in funding this year would totally disrupt the education and employment networks for nursing and other health professionals.

Data Collection and Accountability

Uniformity of efforts in developing comprehensive data on health manpower is fundamental to implementation of this Nation's health planning policies. The Federal government has every right to know how its dollars are being spent. Data collection which is centralized and comparable between schools, health care facilities, state and local governments and health planning agencies is a necessity. We can only match available health resources with this country's relatively high unmet level of consumer needs for access to health care service if we develop a data bank upon which to base future decisions.

One deficiency the Federation recognizes in current data collection is lack of information on hospital work settings where over half of all nurses and allied health professionals are employed. One area of specific concern reflects retention problems of hospital-based health professionals.

The Federation suggests the Committee consider Federal support for a uniform data collection network operated through already-existing health systems agencies. We feel that the HSAs are already looking at geographic distribution of health services, community health needs and appear to be the obvious clearinghouse for analyzing use of health manpower resources.

Capitation and Special Project Incentive Grants

We support the provision of H.R. 2004 which recognizes the increasing trend toward part-time education by providing capitation incentive grants on full-time and full-time equivalent students.

The Federation supports the bill's recognition of the need for more clearly-defined career ladders for nurse education programs through the added incentives given to various educational institutions to recruit students to upgrade their existing skills and professional status. This approach begins to address the problems of career advancement for existing nurses. These problems have included the high cost of higher education, limited number of suitable programs available, metriculation problems between programs (no career ladders), and the failure by programs to recognize past work experience. We support the type of incentive capitation funds for nurse education programs as outlined in this bill. There should also be a mechanism developed for accountability in the use of capitation funds so as to ensure program enrichment rather than just support for administrative costs.

Grants available to schools of medicine, osteopathy, dentistry, and veterinary medicine, etc., which enable them to meet the cost of recruitment of women should also be available to schools of nursing to meet the cost of recruitment of both men and women. With 100,000 unfilled nursing jobs in this country and overall applications to nursing programs declining, we are apt to encounter greater shortages unless funding to support recruitment efforts is forthcoming.

Availability of increased funding for special projects which provide for LPNs and RNs to continue their education is strongly supported. These men and women who return to school are highly motivated, have a tendency to stay in the workforce longer and are most likely to continue their education through the Masters level and beyond which in turn helps meet critical needs for administrators, supervisors, educators and researchers. Funding for special projects should also give support to education programs which assist nurses to re-enter practice. This approach would be invaluable since technological change in the industry continues and these individuals need incentives to go beyond some of the reasons which cause nurses to leave practice, such as child rearing and poor working conditions.

Student Assistance: Scholarships and Loans

We assert a strong belief that nursing education has consistently improved, and that the quality and amount of supervised clinical practice has increased over the years -- not decreased. We support any efforts aimed at further improvement of clinical practice. For example, there are increasing opportunities for internships for graduate nurses which, hopefully, will address this goal. To assure access to these programs, loan repayment deferrals should be available to nurses serving internships just as they are to other health professionals, including physicians.

Loan repayment deferrals for these internships should be provided for nurses enrolled in programs offered by institutions of higher learning to make sure that they meet the needs of the students first, and the service requirements of the health institutions second.

We urge continued funding of traineeships at their present levels. The shortage of qualified personnel for administrative, educational, and research positions remains acute. Because 75% of all nurses in this country are below the baccalaureate level, the number of nurses available for graduate study is severely limited. However, a major priority should be to increase the access to their education.

Availability of loan forgiveness should be tied to length of time the nurse remains in practice as well as time served in areas of priority need for nursing care, both in state and out of state. The ability to repay the loan based on salary earned should be considered. While we support the concept of service in exchange for financial assistance, many who enter nursing studies will be unable to leave their home area for personal reasons. It has been demonstrated that providers indigenous to an area are better equipped to deal with the problems of that area and, therefore availability of in-state service should be added.

Legislative intent should encourage grants and scholarships for the 75% of nurses who are having difficulty upgrading their skills through BSN programs. Nurse practitioners and nurse anesthetists often earn wages that are far in excess of the staff nurse and they are better able to repay loans. The Federation believes that higher earning capability and loan availability should be incentive enough to encourage enrollment in nurse practitioner and nurse anesthetist programs. Competition for admission to these programs is great, which proves this point.

Allied Health Professionals

Federal grants to education programs for existing categories of allied health professions should be continued at its previous level. While primary emphasis is with basic education programs among health professions, new incentives for programs which develop career ladders should be fostered. Health profession education programs, both at the community college and university level rather than in hospital-based programs, will enhance development of a career ladder approach.

National Advisory Councils

The Federation supports cooperative efforts between the existing national advisory councils on education for nurses, other health professionals and graduate medical students. However, we also recognize that each advisory council has a unique role to play in the health planning process and therefore, should be

allowed to exist separately in order to meet specific needs for those three areas of health manpower. We recommend that the name of the advisory council for nursing be changed to the National Advisory Council on Nurse Education and that membership on that council specifically include student nurses, AFL-CIO nurses and licensed practical nurses.

* * *

The facts in the marketplace reveal a shortage of practicing nurses. While the Federation maintains a firm belief that problems of nurse retention are directly related to the need to control wages, benefits, working conditions and patient care through collective bargaining, we also recognize that without continued Federal support to correct utilization of nurses in the health care marketplace there will be a shortage of practicing nurses. H.R. 2004 makes a major contribution toward redressing the problems of working nurses through the sections which provide funding for part-time adult learners, and encouragement to career ladders programs. However, the Federation feels that more emphasis should be given to scholarships for working staff nurses.

We appreciate this opportunity to present our views.

STATEMENT

ON

NURSE TRAINING AMENDMENT OF 1981

FOR THE

HOUSE OF REPRESENTATIVES COMMITTEE

ON ENERGY AND COMMERCE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

By the

NATIONAL STUDENT NURSES' ASSOCIATION, INC.

10 COLUMBUS CIRCLE

NEW YORK, NEW YORK 10019

Wednesday, March 4, 1981

Presented by: Mary Copeland
Nursing Student
Harding University
Searcy, Arkansas

The National Student Nurses' Association is pleased to have this opportunity to present these comments on the Nurse Training Amendments of 1981 in HR 2004. NSNA is the 35,000 member organization for undergraduate students of nursing.

It is unfortunate that legislation for support of nurse education was not enacted by the 96th Congress before its adjournment. This yearly process of attempting to gain passage of provisions for nurse education is costly and time consuming for you and us, and leaves students and nursing education programs in great uncertainty about their future. We are most hopeful that a bill will finally be passed in this session of Congress.

Now more than ever, nursing education stands in need of federal support for its continuation and improvement. There has been a great deal of controversy recently about whether or not there is a nursing shortage and a Congressionally mandated Institute of Medicine study is in progress on this subject. However, it cannot be denied that there is a shortage of nurses practicing in underserved areas and in certain specialty areas. Provisions of HR 2004 can help provide some remedies for this situation by increasing nurses' preparation and incentives for practice in these areas.

The National Student Nurses' Association clearly recognizes the spending constraints all of us are living with. Current expenditure of public funds must be conservative and produce provable, cost-effective results. We feel that federal support for nursing education can help to provide for preparation of competent nurses who can work in underserved and specialty areas, and provide cost-effective health care to the general population.

In this statement we wish to address the area of nurse training in HR 2004, particularly assistance to students.

Institutional Support

We are pleased that HR 2004 will continue a program of institutional support to schools of nursing. Tuition costs to students have been rising sharply in the past few years. However, tuition alone is not nearly enough to cover the costs of an educational institution to turn out a graduate.

Other sources of funds for nursing educational programs, such as private philanthropy, are decreasing as reliable alternative sources of income. Schools of nursing who wish to undertake innovative programs and enrollment activities need a source of financial support. Inclusion in the Nurse Training Act of an institutional support mechanism for

schools meeting specified enrollment objectives or educational priorities would assist the schools as well as helping meet national health needs. Of particular importance are the provisions for institutional support aimed at an increase in the number of B.S.N. programs available to graduates of diploma and associate degree nursing programs, an increase in the number of graduates of nursing education programs who practice in underserved areas, and an increase in representation of minority/disadvantaged groups.

Statistics indicate that admissions, enrollments, and graduations of blacks and men in basic nursing programs have decreased between 1975 and 1978. The proportion of blacks admitted in 1975 was nine and one tenth percent; in 1978, seven and two tenths percent. Enrollment and graduation figures have declined similarly.

Special Projects Grants

This provision has provided funds for nursing education programs to undertake projects to increase the numbers of minority students in nursing and also for innovative educational programs for both formal and for continuing education. We support its continuation in this legislation, particularly with the changes which emphasize increased opportunities for disadvantaged individuals and improvement of geographic distribution.

Advanced Nurse Training

The health field is desperately in need of nurses prepared at the graduate level. Presently, approximately four percent of nurses are prepared at the master's or doctoral level. Many geographic areas simply do not have graduate nursing education programs available. These programs are the source of nurse educators, administrators and nurse clinicians, prepared for employment in primary as well as acute care settings. As an undergraduate student association, we strongly see the need for competent, qualified nurse faculty members to educate today's nursing students. The need for nurses with administrative and supervisory preparation is also acute.

Nurse Practitioner Programs

This, in the past, provided for preparation of nurse practitioners with an emphasis on primary health care in geographically underserved areas. The nurse practitioner is able to practice in sites without full time physicians, thus providing a source of primary health care to underserved populations. No specific cost data is available, but education of a nurse practitioner is less expensive than that of physician preparation, although the scope of practice does differ.

ASSISTANCE TO NURSING STUDENTSTraineeships for Advanced Nurse Training

As stated above, the need for nurses prepared at the master's and doctoral level as educators, administrators, and primary care clinicians is acute. Many nurses currently enrolled in or planning to enter these education programs are at midcareer, when it is extremely difficult to cease full time professional employment and enter a full time education program, both financially and personally. These individuals need financial support, and are ineligible for the bulk of state and private financial aid resources.

Student Loans

For the 1980-81 academic year, the nursing student loan program is being used by approximately 1,145 nursing education programs with an estimated 16,700 students participating. Loans have become the primary source available for nursing students to finance their educational costs. A 1980 survey of members by the National Student Nurses' Association showed that fifty-seven percent surveyed received some type of federal financial aid. Of those receiving federal aid, forty percent were recipients of

federal nursing student loans. Eighty-five percent of the students receiving federal aid stated that they could not continue school without that assistance.

Nursing students are in an unusual situation as far as financial aid is concerned. Most nursing education programs that prepare a student for initial licensure as an RN take place at the undergraduate level, in an associate degree, baccalaureate, or diploma program. This is in contrast to the health professions whose initial preparation is at the graduate level. However, even though they are undergraduates, the cost of nursing education to the student and the institution is higher than that of a liberal arts candidate.

Nursing students have additional expenses for uniforms, laboratory fees and textbooks. In many cases the student must also own a car to get to clinical experience sites, particularly those involving community health. Adding to the cost educating nurses is the fact that the faculty/student ratio must be much lower, particularly in clinical settings.

In the NSNA survey cited above, sixty-one percent of the students surveyed held jobs to meet education and maintenance costs in addition to going to school. After graduation, the student can look forward to an average salary of less than \$13,000 per year, out of which educational loans must be repaid.

The creation of a separate cabinet-level Department of Education has created some speculation and suggestion that undergraduate nursing students' assistance should come under this department with other undergraduate students, and that nursing students should make increased use of the Guaranteed Student Loan Program and Basic Educational Opportunity Grants. This would create several problems. Under present regulations, nursing programs participating in the Nursing Student Loan Program cannot participate in the Guaranteed Student Loan Program. As already stated, the cost of nursing education is higher than the average, which is not allowed for under these general programs. Additionally, nursing students cannot be equated with a basic liberal arts student, because they will be prepared to practice nursing upon graduation and licensure, meeting a national need. If the purpose of having a Nurse Training Act is to prepare nurses who can better meet designated U.S. health delivery needs, undergraduate nursing student assistance designed to help in meeting these needs should remain a priority in the Nurse Training Act. Continuity between undergraduate nursing student assistance and other provisions of the Act is important, to avoid further dilution of federal Nurse Training incentives.

Of course, NSNA realizes that federal financial assistance to nursing students carries an expectation that the recipients will use their educational preparation to meet na-

tional health priorities and needs. Loan repayment for service in a geographically underserved area or specialty area is one method by which this can be accomplished. In the NSNA survey, seventy-two percent of the students receiving federal assistance said that they would be willing to practice in an underserved area as an option to repay a federal loan. Therefore, preferential availability of loan money to students planning to practice in primary care or underserved areas should seriously be considered. Nurses enrolled in graduate nursing education programs, or other specified national priorities is another option. Nursing students are not asking for a free education at government expense but are asking for help to complete nursing education and enter active nursing practice.

Scholarship Grants

We are concerned about the proposed discontinuance of the nursing student scholarship program. Most nursing students realize that student loans are the main mechanism they can expect to use to finance their education. However, there are students with exceptional financial need, particularly students from disadvantaged groups, for whom the burden of debt resulting from large amounts of student loans is prohibitive. Scholarship grants enable qualified students in financial distress to complete their education when it would

otherwise be impossible. We urge the continuation of the scholarship grants.

Summary

The National Student Nurses' Association believes that continued federal support to nursing education through the Nurse Training Act is vital. Since the emphasis is shifting from simply increasing the numbers of nurses to increasing the number of nurses prepared to practice in geographic or specialty underserved areas, the need is more acute. No one has yet found a guaranteed way to accomplish this, and nursing education programs and nursing students need financial support to explore new, more effective methods to meet the health problems of the U.S. in the most efficient and economic way.

3/4/81

STATEMENT

OF

The Coalition for Allied Health Professions Education

The Allied Health Community

Mr. Chairman, the Allied Health professions are heterogeneous in the extreme, differing in the competencies they require, their respective requisite educational preparation, the scientific foundations for their knowledge bases, and the clinical and educational roles which they play in the nation's health-care delivery system.

Required competencies vary from the performance of relatively routine tasks to the highest levels of education and service-delivery administration and the generation of new knowledge through research. Similarly broad is the range of educational preparation the Allied Health professions require -- from limited post-secondary training to postdoctoral study. The time required for such preparation ranges from several months to more than a few years. The scientific foundations of Allied Health profession expertise range from several months to more than a few years. The scientific foundations of Allied Health profession expertise range from the biological and chemical sciences (e.g., clinical laboratory professionals), to the social sciences (e.g., social workers and clinical psychologists), to combinations of the physical and social sciences and the humanities (e.g., speech pathologists, rehabilitation counselors).

Some Allied Health professionals are involved primarily in institutional patient care, others in community health promotion and protection, still others in health-care research,

manpower training, and education and service delivery administration. The range of Allied Health services includes:

- emergency services (e.g., emergency medical technicians, physician assistants);
- reception and screening (e.g., medical and dental secretaries, medical office assistants);
- initial evaluation and diagnosis (e.g., audiologists, physician assistants, dental hygienists, mental health technologists, medical social workers);
- continued assessment as part of treatment (e.g., physical therapists, occupational therapists, respiratory therapists, speech pathologists, audiologists, dietitians);
- testing (e.g., medical laboratory personnel, radiologic technologists, ultrasound technical specialists, nuclear medicine personnel, cardiology equipment personnel);
- acute care therapy (e.g., operating room technicians, obstetrical assistants, surgeons' assistants);
- long-term care therapy (e.g., occupational, physical and other therapists; personnel in mental health and social services, counseling, speech pathology, audiology, nutrition);
- medical instrumentation (e.g., radiation and respiratory therapists, dialysis technicians, cardiopulmonary technicians, ophthalmic dispensers, dental laboratory technicians);
- community health promotion and protection (e.g., nutritionists, dental hygienists, population and family planning specialists, health educators, school health educators, medical librarians, health writers);
- environmental health promotion and protection (e.g., sanitarians, environmental health technicians, sanitarian aides, environmental engineering assistants);
- control and elimination of hazards in an institutional or industrial setting (e.g., audiologists, health physicists, health care facility housekeepers, industrial hygienists);

- health systems management (e.g., hospital administrators, health planners, medical records personnel, medical computer specialists);
- research and development (e.g., biomedical engineers, biostatisticians, epidemiologists, toxicologists, public health scientists, and researchers in every occupational category).

An essential feature of Allied Health education since the 1960s has been its rapid change and expansion, characterized by the following three major ingredients: First, there has been a tremendous growth in the number of programs, particularly in collegiate settings, which has paralleled the great expansion of two-year colleges and the growing popularity of vocational programs (in 1966, there were an estimated 2,500 collegiate programs; today there are over 8,000); second, the distribution of programs has changed -- hospitals and other health-service settings still play an important role, but the greatest program growth has occurred in such other settings as medical centers and universities, two-year colleges, vocational technical institutes, and private career schools; third, a dramatic expansion of knowledge and skill requirements has led to increased diversification of educational requirements.

In 1976, the latest year for which there is adequate survey information, there were about 14,000 formal postsecondary programs for Allied Health personnel. Of these,

- 52 to 54 percent were in collegiate settings
- 33 to 35 percent were in hospitals
- 10 to 12 percent were postsecondary non-collegiate institutions, and
- one percent were in the armed forces.

Over half of the nation's 3,000 higher education institutions have at least one Allied Health program. Such programs are contained in about 90 percent of the nation's research universities and doctoral-granting institutions, as well as in large proportions of comprehensive colleges and universities, free-standing medical centers, and two-year colleges. Significantly more than half of all Allied Health programs in collegiate institutions award degrees at the baccalaureate or higher level.

It may be important to point out here that these patterns of education for the Allied Health professions have grown out of practice needs, rather than from abstractly determined sets of values. Thus, the history of Allied Health education, brief as it is, is closely related to the history of the occupations themselves. The burgeoning of the Allied Health professions and of Allied Health education is the product of increased and increasing health-service demands and the explosive growth in health science and technology.

Manpower data collection is not what it might be -- what we hope it can and will be -- in the area of Allied Health. Still, we can say with reasonable assurance that, as of 1978, an estimated 3.5 million individuals (nearly 66 percent of the total health-care work force) could be classified, in the broadest sense, as Allied Health practitioners. The core of this population -- the professions in which the federal govern-

ment has invested the bulk of its Allied Health manpower-training funds and which, generally, require collegiate preparation ranging from the associate degree to the doctorate -- has grown from 442,000 in 1966 to approximately 1,026,000 in 1978. This 132-percent rate of growth compares with a 76-percent growth rate for all health professionals.

Yet despite this growth, the Department of Health and Human Services Bureau of Health Manpower (Health Resources Administration)* tells us that there are still clear and significant national Allied Health manpower shortages in such professions as audiology, speech pathology and respiratory therapy. And though the data is not definitive, it also appears to the Bureau that there still may be national shortages of dietitians and dietetic technicians, radiation therapists, physical therapists, occupational therapists, and formally-trained dental assistants.

Federal Support of Allied Health Education

Federal support for Allied Health manpower training was first authorized in 1966 by the Allied Health Professions Personnel Training Act. During the first four years of operation under its authorities, the statute put primary emphasis on increasing the number of training programs and professionals. In the early seventies, however, the statute was amended, its emphasis shifted: Basic improvement grants, which encouraged the establishment of new scholastic programs,

* Report (to Congress) on Allied Health Personnel, DHHS Pub. No. (HRA) 80-28

were abandoned in favor of new focuses and initiatives, relating more to the provision of quality Allied Health education and health service than to the production of increases numbers of Allied Health professionals. The shift clearly was occasioned by public economic policy, and not by evidence that manpower needs had been met -- there were at least as many "significant" national professional-area shortages at the start of the seventies as there are today.

The new funding focuses were on special educational projects for Allied Health training programs (one special project focus addressed the need for the "establishment of new roles and functions for Allied Health" personnel), on faculty development through a mechanism called "advanced traineeships", and on the recruitment to the Allied Health professions and retention of ethnic minorities-group members.

Funding authorizations which followed the shift from the early basic improvement grants to the special target grants and contracts were moderate, to say the most. But this moderate support soon became virtually no support at all. In fiscal year 1973, for example, Congress provided \$30.2 million to support Allied Health planning, development and operation of such (sections 796, 797 and 798) projects as the establishment of regional systems for coordinating and managing Allied Health training; of new and improved methods of credentialing Allied Health Personnel; of recruitment, training and retraining programs; of career ladders and

other programs of advancement; of continuing education programs; of faculty training institutes; and of ethnic minority-group member recruitment. Two years ago, following a Carter Administration call for zero funding of Allied Health manpower-training programs and projects, the Allied Health community was able to win congressional support for a \$10 million fiscal 1980 appropriation for these Part G (Title VII) initiatives (one-third of that amount subsequently was rescinded). Last year, the Carter Administration again called for a zero funding level. After Congress appropriated \$6.7 million for fiscal 1981, President Carter called for a rescission of all of that amount and the new Administration appears similarly inclined.

The rationale of both Administrations for these terminal reductions makes no sense at all. Spokesmen for both Administrations have listed cost effectiveness, the delivery of services to unserved and underserved areas of the country, disease prevention and health promotion, and the involvement of ethnic minority-group members in health-care education and service delivery as major national health-care objectives. Yet, the Carter and Reagan Administrations have urged Congress to refuse any support for that segment of the health manpower population which is best prepared and best able to address these objectives.

Both Administrations also have said that, inasmuch as there are no manpower shortages among the Allied Health professions, "continued federal involvement in basic Allied

Health training support" is unwarranted. The argument both denies and defies the reality of the Report of the federal government's own health-manpower agency, which not only makes a "case for continued Federal activity on behalf of allied health personnel," but also lists a relatively large number of key Allied Health professions in which there are "significant national shortages." But more -- both Administrations have overlooked the fact that federal Allied Health manpower-training fundings is expressly intended by statute for special-target projects and not for basic education support. Indeed, such basic support hasn't been available to the Allied Health professions for the better part of a decade!

Some might argue that the \$283 million invested by the federal government (since 1967) in Allied Health manpower training is not only a substantial amount, but an appropriate amount as well. Substantial it well might be; appropriate it most assuredly is not. The \$283 million figure -- the federal government's total 14-year commitment to two-thirds of the nation's health-care workforce -- represents merely four percent of the total federal investment in health-manpower training and development. From its beginnings, Allied Health has been relegated by the federal government to but a cubby hole in the great mansion of health-care education. Today, there's an eviction notice on our small door. We hope this Subcommittee will tear down that notice and, in doing so, give notice of its own that Allied Health can must and will be counted on

by the federal government as a major partner in the development of an effective manpower-training and service-delivery effort.

Bureau of Health Professions Recommendations

The Coalition believes that the federal government must assume a leadership role in helping fill what HRA's Bureau of Health Professions terms as "significant national (Allied Health) shortages."

In addition, we see a major federal responsibility in the fulfillment of these of the Bureau's Allied Health related recommendations:

1. "Information including statistical data on allied health personnel requires continued improvement, by larger investments and co-ordinated activities ...

"Particularly, data are needed with which to determine the nature and extent of 'critical vacancies' and specific skills shortages, and to plan appropriate local, State, regional, or national education.

"Better data are needed on minority participation in the work force..

2. "Special attention to the allied health personnel problems of small health care institutions is required, to ensure that regulatory and other constraints do not interfere with access to and the quality and continuity of patient care. Additional resources are needed with which to investigate the nature, extent, and impact of these problems, and to devise solutions as may be necessary.
3. "The cost-saving potential of more efficient use of allied health personnel should be thoroughly explored through well-designed and controlled studies carried out in various work settings and not hindered by current legal limitations on the use of personnel.

4. "As personnel standards are changed, training programs must be revised. This requires national coordination and encouragement.
5. "As manpower standards change, personnel working in the field who cannot meet new and more rigorous qualifications must be provided with opportunities to improve their competencies. Support to develop training materials and procedures that will reach the employed work force is necessary.
6. "Methods of testing of individuals to determine competency in the health field require improvement, through additional research, development, and validation, with Federal leadership.
7. "To the extent necessary to ensure adequate numbers of these personnel equitably distributed among and within States, Federal programs must encourage comprehensive State programs to identify and act upon problems of maldistribution and undersupply.
8. "There should be established within the Department (i.e., HEW) the function of review and approval of all Federal policies and actions that lead to or encourage new health occupations or specialties.
9. "There should be established within the Department the function of review and assessment of all Federal policies and regulations that affect the demand for or utilization of health personnel.
10. "Improvement of specific clinical competencies of health personnel is required, through advanced and short-term training and through self-instruction, particularly for the following subjects or functions:
 - long-term care of the elderly and chronically ill,
 - hospice care,
 - disease prevention and health promotion, and
 - application of new technologies.
11. "Improvement in nonclinical, competencies of allied health personnel is required, through advanced and short-term training and through self-instruction, particularly in:

- teaching,
 - educational program planning,
 - administration and supervision, and
 - performance evaluation and assessment.
12. "Maintenance and further development of allied health training centers should be encouraged so that they carry out essential interdisciplinary coordinating and planning activities.
 13. "Additional allied health training centers in institutions with predominantly minority enrollments should be established.
 14. "Activities for the recruitment of and assistance to minority students in allied health training programs should be increased.
 15. "the MEDIHC program (Military Experience Directed Into Health Careers) to place veterans and other allied health personnel in critical vacancies, especially in small and rural institutions, should be continued.
 16. "Statewide and educational system wide planning for allied health occupations education and training, through grants and cooperative agreements, should be encouraged and supported."

Recommendations for Statutory Change

Following are the elements of change which the Coalition for Health Professions Education asks this Subcommittee to include in its version of extended and amended health manpower-training authorities.

1. The Definition of "Allied Health Personnel" and "training center for allied health personnel" {Section 795 (1) and (2)}:
 Current statutory language defines "Allied Health personnel" as "individuals with training and responsibilities for (A) supporting, complementing, or supplementing the professional functions of physicians, dentists, and other health profes-

sionals in the delivery of health care to patients, or (B) assisting environmental engineers and other personnel in environmental health control and preventive medicine activities." The extant statutory portrait of Allied Health professionals is completed in the section 795 (2) definition of "training center for Allied Health professions," which lists as the only examples of those professions "medical technology, optometric technology, and dental hygiene."

The portrait is inappropriate and, as we shall offer later, largely unnecessary. It is inappropriate for three reasons:

- a. The definition uses the term "personnel" rather than the term "professional." Physicians and dentists and unidentified others are "professionals;" Allied Health practitioners are "personnel." The distinction is inappropriate and, we think, derogatory.
- b. The definition suggests that Allied Health professionals always and everywhere work for or under the supervision of physicians, dentists and environmental engineers. That's simply not true.
- c. Finally, the definition puts forward as explicit examples of Allied Health practitioners not the physical or occupational therapist, the audiologist or speech pathologist, the dietitian or clinical psychologist, but rather the individuals who function (medical technologists excepted) as aides and assistants. The examples are not inaccurate -- these professionals are Allied Health practitioners; they are, however, not nearly as representative of the Allied Health fields as other choices would be.

Let us cite just one example of the unfortunate effects of the present definition's inappropriateness: The American Speech-Language-Hearing Association has long suggested to its members that they should not seek federal training assistance

under the Part G Allied Health authorities of Title VII. To do so, the Association has said, would be to admit that speech pathologists and audiologists are something less than "professional." Training program directors who are members of that distinguished Association agreed -- principle was the preeminent importance. It should come as no surprise, then, that speech pathology and audiology are two of the three Allied Health professions in which, according to the Bureau of Health Manpower, there are critical manpower shortages nationwide.

During Congress' last term, the Senate approved legislation which, insofar as its Allied Health related references were concerned, the Allied Health community supported enthusiastically. Among other things, the bill (S.2375) contained a proposed amendment to section 795 of the Public Service Act. Under the amendment,

... subsection (1) would be changed to read:

"The term 'Allied Health personnel' means individuals trained at the associate, baccalaureate, master's, or doctoral degree level in a health care related science, with responsibility for the delivery of health care or health care related services (including services related to the identification, evaluation and prevention of diseases and disorders, dietary and nutrition services, health promotion, rehabilitation, and health systems management), but who, for the purposes of this title, are not graduates of schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, or nursing."

.. subsection (2) of section 795 would be changed to read:

"The terms 'School of Allied Health' and 'training center for Allied Health professions' mean a public or non-profit private junior college, college, or university -- (A) which provides, or can provide, programs of education in a discipline of Allied Health leading to a baccalaureate or associate degree (or an equivalent degree of either) or to a more advanced degree; (B) which provides training for not less than a total of twenty persons in such curricula; (C) which includes or is affiliated with a teaching hospital; and (D) which is accredited by a recognized body or bodies approved for such purposes by the Secretary of Education or there is satisfactory assurance afforded by such accrediting agency to the Secretary that reasonable progress is being made toward accreditation."

The Coalition for Allied Health Professions Education urges the inclusion of this section 795 amendment in the Subcommittee's version of new health manpower training authorizing legislation.

2. Advisory Council Inclusion of Allied Health Representation:

The Coalition additionally supports an amendment to existing section 702 (a) language that would accommodate representation on the National Advisory Council on Health Professions Education by a representative of Allied Health schools, and potential representation by a student enrolled in an Allied Health curriculum. The Council has gone too long without a representative of the educational institutions which train the largest segment of the health care workforce. We, therefore, recommend that the Subcommittee adopt an amendment to section 702(a) of the Act that would

add representatives of Allied Health schools (and of the student bodies of such institutions) to those health profession school representatives presently listed in section 702 (a) of Title VII as members of the National Advisory Council on Health Professions Education.

3. Data Collection in Allied Health: According to the recent reports of the Bureau of Health Professions and the National Commission on Allied Health Education,* support for data collection in Allied Health should be at the top of the federal government's Allied Health support agenda. Says the Report of the Bureau of Health Manpower:

"There are insufficient data about allied health personnel at the local, State, or national level to permit radical improvements in planning, production, and management. The large number of occupations and functions involved, and their interrelations, makes good planning for allied health personnel difficult. Improved data on production, recruitment, reimbursement, utilization, service cost, and work force quality are needed. Data on improvements in supply, work force quality, educational standards and methods, and opportunities for minorities are difficult and costly to produce and generally less than satisfactory. Where improvements have occurred, Federal support appears to be a decisive factor."

According to the National Commission:

"The federal government should support the systematic and continuous collection and dissemination of data on the numbers and distribution of health manpower in all occupational areas, including information on projected openings. Support also should be made available for the continuation of biennial national inventories of Allied Health programs, expanded to include all settings which offer formal post-secondary education programs."

The Commission's emphasis on data collection from "all occupational areas (and) settings which offer formal post-

* The Future of Allied Health Education, Jossey-Bass, Publisher (San Francisco), 1980.

secondary education programs" merits special note. At present, the federal government supports Allied Health related data collection which relates only to Allied Health schools defined in existing section 795 (2) -- i.e., schools which award the associate or baccalaureate or higher degree. There is, however, a large number of certificate-awarding Allied Health institutions (and an increasing number of Allied Health aide, assistant, and orderly-type graduates of such schools) regarding which data are not being collected. Clearly, this data need to be gathered and analyzed. Such data should be and, we would urge, can be gathered without altering in any way the statutory definition of the Allied Health schools which are appropriate recipients of federal training support.

There also is a pressing need for feasibility studies on the collection of data relating to ethnic minority-group member involvement in Allied Health training and practice. Data on approaches to career counseling, recruitment, admissions, and retention of minority-group students in training programs are required, so that we can understand (and deal with) the reality of greater student involvement at lower levels of training. We also need definitive studies on the impact of minority institutions on the overall Allied Health manpower pool and on the reasons for unique minority-group member practice patterns and geographic distribution.

In view of the foregoing, the Coalition asks the Subcommittee to --

either amend the existing data-collection language of 708 or add a new section to Part G to accommodate the the need for the collection of Allied Health related data from schools of Allied Health (including post-secondary nonprofit and proprietary institutions which grant practice "certificates" in Allied Health disciplines), including data relating to production, recruitment, reimbursement, utilization, service costs, workforce quality, educational standards and methods, and opportunities for minorities.

4. Allied Health Project Support: Existing section 796 authorizes grants and contracts to "eligible entities" for special projects which are detailed in subsection (a)(1) of the section. With one notable exception (i.e., projects to establish "new roles and functions of allied health personnel"),

the purposes of section 796 should be retained in the Subcommittee's final legislative proposal. In addition, the following project-support emphases should be added to those already enumerated: projects which focus on Allied Health role delineations and related interdisciplinary curriculum modules; on meeting new health-service needs without creating new specialties; on the development of mechanisms for interdisciplinary articulation; on the use of Allied Health practitioners in containing health-care costs; on the Allied Health related needs of unserved and underserved areas; and on curriculum offerings in health promotion, disease prevention, geriatrics, and health planning. The authorization levels for existing section 796 should be \$10 million for fiscal 1982, \$12 million for fiscal 1983, \$14 million for fiscal 1984, and \$16 million for fiscal 1985.

5. Training Institutes in Allied Health: Existing section 797 authorizes grants for the conduct of short-term "institutes" generally designed to accomodate the "advanced" learning needs of Allied Health practitioners who, principally as a

result of the rapid expansion of the Allied Health fields and increases in the numbers and varieties of Allied Health opportunities and initiatives, find themselves in new educational, supervisory or administrative settings. The Society believes that this emphasis should be continued and, therefore, recommends that the final Subcommittee proposal should --

include existing section 797 through fiscal year 1985 at an annual authorization level that is no less than \$1.5 million.

6. Ethnic Minority-Group Allied Health Education: As the National Commission on Allied Health Education points out, the Allied Health professions, because they are among the few professions in the economy for which the employment outlook is almost uniformly favorable, "represent an excellent avenue for social mobility" on the part of ethnic minority-group members. Moreover, notes the Commission, "minorities are substantially underrepresented in educational programs for the relatively high-level Allied Health occupations (i.e., baccalaureate and advanced degree levels)." Minority Allied Health training programs also are underrepresented among programs receiving Allied Health training assistance from the federal government. In the last year for which data are available (1975), the 563 Allied Health discipline programs situated in minority institutions represented 10 percent of the total Allied Health program offerings. Yet minority institutions received only six percent of Allied Health training

assistance made available through the Bureau of Health Professions. The Society asks that the Subcommittee include in its final legislative proposal authorizations designed to --

provide student support for disadvantaged ethnic minority-group members enrolled in Allied Health education programs (especially in baccalaureate and graduate programs), and special program support for Allied Health education programs in traditionally and predominantly minority institutions. In addition, the special recruitment and related emphases of existing section 798 should be continued at an annual authorization level of no less than \$1 million.

Mr. Chairman, we are grateful for this opportunity to present these our views to you and your colleague Subcommittee members.

STATEMENT OF THE
ASSOCIATION OF SCHOOLS AND COLLEGES OF OPTOMETRY
AND THE
AMERICAN OPTOMETRIC ASSOCIATION
ON
HEALTH PROFESSIONS EDUCATION
(H.R. 2004)
TO THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
OF THE
COMMITTEE ON ENERGY AND COMMERCE
UNITED STATES
HOUSE OF REPRESENTATIVES

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March 24, 1981

The Association of Schools and Colleges of Optometry and the American Optometric Association appreciate this opportunity to submit comments on the specific proposal (H.R. 2004) that has been introduced to extend the programs of assistance for the education of health professions personnel.

The Association's sixteen member educational institutions in the United States are dedicated to training doctors of optometry necessary to meet the primary vision care needs of the American public. We represent a limited national resource and are vitally interested in the legislation under consideration.

We have reviewed H.R. 2004, introduced by Mr. Waxman on February 23, 1981, which makes certain amendments to existing legislation in support of education of health professionals. We are pleased to have the opportunity to provide our comments to this proposal and to suggest additional amendments to address present and future issues in the national interest.

H.R. 2004 would extend the National Health Service Corps program and its related Scholarship program. This program is designed to provide for unmet health care needs in health manpower shortage areas. Unfortunately, the administration of the National Health Service Corps has not addressed the unmet vision care of such areas even though extensive shortages exist. Presently there are 248 designated counties requiring over 350 practitioners. We urge the Committee to include specific language to include optometry for primary vision care needs and that scholarships be allocated in proportion to this shortage.

With the high cost associated with Federal employment and utilization of health personnel we support the bill's intent to have

obligated health personnel serve in private practice circumstances. We recommend that more specific incentives be included in the legislation to make private practice preferable.

The Association of Schools and Colleges of Optometry contends that the present schools cannot produce the needed number of practitioners for the future. There is also a significant geographic disparity with only 16 schools. This results in educational limits for many possible students. We are therefore supportive of continuation of construction assistance as provided under Sec. 720. This, combined with continuation of Start-Up grants under Sec. 788 will provide the opportunity for development of the needed additional facilities to meet future requirements.

The bill would continue the health professions loan programs. Our students have participated in the Health Professions Student Loan Program as the primary source of loans for their educational needs. With the high cost of education the availability of low cost loans is of the highest priority. We support this proposal.

Scholarships for Students of Exceptional Financial Need under Sec. 758 have been employed by our schools to encourage minorities and other disadvantaged to pursue optometry as a profession. We are pleased with the intent to continue this support.

H.R. 2004 proposes an institutional support program which for optometry would authorize \$350 per student during the first year and \$100 in FY 1983. Our educational programs are in need of Federal support. Having anticipated the possible loss of this direct type of support the majority of our member schools have begun to identify possible alternative funding sources and accept the phasing out approach to this Federal subsidy. Sec. 770(a)(3) establishes

the support level at \$350 and 770(d) the appropriation authorization of \$529 thousand and \$265 thousand in FY'82 and '83 respectively. With approximately 4800 students in our schools the required funding level is \$1.68 million for the first year and \$480 thousand the second year. Sec. 770(d)(5) should be amended to reflect the required funding levels.

We are pleased to note the striking of the 50% requirement for our private institutions under Subsection (g)3(3) of Sec. 771.

Sec. 712 of the proposed legislation would establish in law the Graduate Medical Education National Advisory Committee. We had previously testified favorably in this regard. Following the issuance of the GMENAC report and our further review of the Committee function we are uncertain of its future. The Secretary, HHS, did not see fit to extend this Committee and is presently reviewing its work and comments made on the report. In view of this we recommend that the Congress defer action on this issue until further evaluation and justification can be completed.

Optometry has been supportive of the Area Health Education Center concept. We have not, however, been actively included in any of the existing projects. We urge the Committee to incorporate grant incentives into the legislation for the inclusion of optometry and other professions in these centers.

In December, 1979, our Association developed an issues paper on health manpower needs and suggests Federal initiatives to address these issues. We are pleased to make a copy of this paper available for the Committee's consideration. The issues and our considered approach remain valid at this time.

We congratulate the Committee on moving forward with health manpower legislation and urge action at the earliest possible date.

12/79

ASSOCIATION OF SCHOOLS AND COLLEGES OF OPTOMETRY

The Federal Government has a continuing role in the support of health professions education to assure the availability of appropriately trained health manpower to implement its various social concerns as expressed in health policy relating to the public need.

The emphasis of health professions education support must shift from the production of numbers of health professionals, now considered adequate, to the implementation of other higher policy concerns:

1. Encouraging and supporting an equitable opportunity for minorities and disadvantaged individuals to pursue a career in the health professions.

Rationale: a) The increasing costs of health professions education and the decreasing availability of student loans and scholarships strongly indicate that minorities and disadvantaged students are being increasingly denied access to health profession education.

- b) The existing loan programs not only are decreasing in availability but also place students in such a debt position that they are unable to borrow the additional funds to start a practice, particularly in rural and inner city areas where the need is great but the growth of the practice is likely to be too slow to carry the additional debt.

Recommendation: Develop a scholarship program for the support of minority and disadvantaged students, perhaps tied to the National Health Service Corps, involving 75% federal funds and 25% State funds in a matching program for the MOD/VOFF professions. Such a program should provide funds at a rate comparable to graduate research training

grants and be administered in conjunction with contract programs of Regional Education Boards (SREB, WICHE, NECHE, etc.).

2. Encourage the development of programs in the health professional schools that address the issues of quality of care, competency assurance and cost effectiveness.

Rationale: a) The escalating costs of health care are a national concern.

Health professions schools all of whom operate clinical service and training programs, many of which are addressed to tertiary care, have paid little attention to programs of cost effectiveness and cost containment.

- b) The documented increase in iatrogenic complications, inappropriate and unnecessary procedures is not being controlled by PSRO programs nor have the health professional schools seriously addressed their responsibility for continuing competency assurance and quality standards.

Recommendation: Develop a program of support for health professions schools to utilize faculty expertise in the development within their educational clinics of model programs for cost effectiveness and quality assurance.

- ③ Encourage the development of programs of health promotion, prevention and health protection in the educational programs in the schools of the health professions.

Rationale: a) As the leading causes of death and disability continue to shift to the factors related to the environment and to personal life-style, there is a growing awareness of these factors on the part of the public, to which the health professionals have contributed very little

- b) The Surgeon General's report emphasises the positive

gains in health status and the potential of cost containment in health protection and promotion. Schools of the health professions have not modified their curricula or programs to support these perspectives.

Recommendation: Develop a program of support for health professions schools to create the curricular changes that will result in the manpower orientation and expertise that the program of health protection, health promotion and disease prevention requires.

4. Encourage and develop the support for the health professions schools to create programs of service that relate to special areas of public need - primary care.

- Rationale: a) Both specialty and geographic maldistribution have been cited as areas of federal concern. These problems will be exacerbated by the overproduction of physicians. This also leads to inappropriate utilization of medical specialists and further escalation of health care costs. While federal support has been provided for the development of primary care physicians, this support has not been provided other health professions programs even though they are clearly providing primary care services.
- b) While there is a relatively equitable distribution of optometrists there are still substantial needs for optometric services in both rural and inner city areas, areas of particular federal concern. Special funding for such clinical services is needed since Medicare and Medicaid funding for services is virtually not available.
- c) Optometric education provides a solid basic health science background for the practice of optometry and with enhanced

training in health assessment, counselling and health screening would provide a major resource for needed primary care.

Recommendation: Develop a special projects program for VOPP schools to enhance health assessment, counselling and health screening utilizing rural outreach and inner city clinical sites.

5. Encourage the development of programs in the health professions schools to develop practitioners for service to special categories of the population of particular public concern.

Rationale: a) There are special age groups that have been singled out for concern by the federal government, namely children and the aging. Both of these groups have a special need for high quality, available services. Schools of the health professions have been slow in providing the trained manpower to serve the unique needs of these groups.

b) The federal government has initiated programs for the development of educational programs for the handicapped. In most States it has been discovered that the necessary professional expertise is simply not available to maximize this opportunity for service to the handicapped nor to initiate the programs of rehabilitation required.

Recommendation: Develop targeted support for the training of health professionals, in all the professions, in primary care, services to children and the aged, and rehabilitation of the handicapped.

6. Encourage the development of programs of institutional research in the health professions schools.

Rationale: a) There have been sporadic and individual efforts to develop a data base of information related to the various health

professions and their schools. Such information is of vital importance to the decision making process of the federal government but is usually incomplete, inadequate or inconsistent.

- b) While each school and each profession needs this type of information to evaluate and guide its planning and decision making, there is also a need for comparable data between schools and between professions. No one school can do this alone but there is real need for the development of an institutional research capability in each school, particularly in times of restrained resources for their support.

Recommendation: Develop a program of support for institution research in each of the health professional schools that can be coordinated into a comprehensive, comparable data base for health professions education.

7. Encourage quality enhancement by supporting the affiliation of free-standing optometry schools with academic health centers.

Rationale: a) The schools of optometry in the nation number only 14, of which 5 are private non-profit free standing institutions. These private institutions, recognizing the significant opportunities for upgrading the quality of their educational programs through amalgamation into an academic health center, have made serious efforts to so affiliate.

- b) The academic health centers have been interested in such a development but have been restrained by inadequate institutional funds and a lack of external support for such a program.

Recommendation: Develop a program for the support of the amalgamation of free-standing optometry schools into academic health centers

to enhance the quality of optometric education and interprofessional relations in a manner that will provide incentives for academic health centers.

8. Develop a program of health manpower distribution responsive to regional needs.

- Rationale: a) Regional education commissions and boards have developed considerable expertise in assessing the health manpower needs of their region for the various professions. They represent an objective and responsive body with concerns that more nearly coincide with the service areas of health professions schools. HSA's are clearly too parochial for such planning purposes, particularly for VOFP schools.
- b) Regional education commissions and boards have developed important contract programs through interstate compacts for the training of health professional students. These programs provide State support for students to attend health professional schools in regional schools where none exist in the home state. These programs are of particular significance to veterinary medicine, optometry and podiatry because of the small number of schools.
- c) While current studies indicate there will be a surplus of physicians in the near future in the U.S., regional studies demonstrate that there are significant needs for veterinary medicine, optometry and podiatry professionals in certain parts of the United States.

Recommendation: Develop a block grant program to be administered by regional education commissions or boards for the development of new schools, clinical campuses and other

innovative educational development, with State cost sharing through the contract program, to meet regional needs for optometrists, podiatrists and veterinarians.

While the above recommendations and rationale address important problems in health manpower in general terms each one has specific application to the schools and colleges of optometry. We have not supplied the detailed back up information at this time but assure you that if the general principles are acceptable we would be pleased to develop such material as needed for the support of optometric education and to assist in the development of legislative specifications.

STATEMENT
OF THE
ASSOCIATION OF CHIROPRACTIC COLLEGE PRESIDENTS
INTERNATIONAL CHIROPRACTORS ASSOCIATION
AMERICAN CHIROPRACTIC ASSOCIATION

HEARINGS ON HEALTH MANPOWER LEGISLATION (H.R.2004)
before the
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES

INTRODUCTION

The Association of Chiropractic College Presidents, the International Chiropractors Association and the American Chiropractic Association are pleased to submit this statement for the hearing record on H.R.2004 and the reauthorization of health manpower programs. We are grateful for this opportunity to share with the Committee the concerns of the chiropractic profession about the federal programs in the health professions area.

We recognize that with federal budgetary constraints, difficult choices must be made by this Committee as it establishes priorities and funding levels for health manpower programs. During this review, it must be noted that while much progress has been made in solving the problems these programs were designed to address, much remains to be done. The progress made in ensuring a well-trained supply of health care practitioners adequate to meet the needs of all Americans has largely been a result of federal health manpower programs. The tremendous gains made by medicine and the other health disciplines in increasing the quality of their academic, research and training programs have been due in no small part to the federal assistance these programs provided.

Sharply escalating costs in health professional education, research and training, however, threaten both to eradicate the gains that have been made and to prevent further advances. Continuing federal assistance will be required if health professional schools are to continue to provide high-quality education at levels affordable to all capable students. The problems of geographic maldistri-

bution and lack of minority and female representation will also continue to require federal assistance.

As this Committee is aware, chiropractic, alone among the major health disciplines, is not eligible for equal participation in the various federal health manpower programs. Without benefit of the federal assistance medical and other health professional schools have received over the years, our chiropractic colleges have nevertheless managed to provide high-quality education to an increasing number of chiropractic students. The exclusion of our schools and students from these assistance programs, however, seriously threatens our continuing capability to do so, and has prevented the chiropractic profession from sharing in the gains made by those health professions receiving assistance under health manpower programs.

The chiropractic profession faces the same problems as those health disciplines included in H.R.2004. The 15 Schools of Chiropractic with status with the Council on Chiropractic Education are suffering from the same financial pressures and developmental problems as are the other health professional schools; the 8,902 students currently enrolled in schools of chiropractic must likewise bear the brunt of rising tuition costs and limited financial aid resources; and the chiropractic profession has not been able to share in the progress made by other health professional groups in meeting the problems of geographic maldistribution and inadequate female and minority representation within the profession.

Exclusion of chiropractic from these programs has been inconsistent with the federal government's recognition of chiropractic.

services under a number of federal health programs, including Medicare and Medicaid. In addition to this federal support, chiropractic has been accorded recognition by both state and local governments and the private sector, and enjoys widespread acceptance among members of the public. Demand for chiropractic services is growing, and there is evidence to suggest that demand for such services may well outstrip supply. Clearly, the federal government has a role to play in ensuring top quality chiropractic education.

As this Committee is aware, the Senate voted last year to include chiropractic in its legislation reauthorizing health professions programs. We urge this Committee to this year act favorably on the inclusion of chiropractic in the health manpower legislation it ultimately adopts. This year will no doubt see reductions in federal outlays for health manpower. Existing inequities, however, must not be allowed to continue under the rubric of "budgetary constraints." The exclusion of chiropractic, although perhaps a testament to the American Medical Association's lobbying intensity, has not been in the best interests of our health care economy. Equal participation by all health professionals for the federal monies that will remain available is, we think, the surest way to lower health care costs through a truly competitive market for health professional services.

Therefore, we respectfully suggest that all involved will profit substantially by Federal support of chiropractic education: The Public, by being able to serve its increasing demand for chiropractic health care; The Economy, by returning impaired workers back to the job more quickly thereby increasing productivity and profit, and

The Federal Government, by expending less funds, on a cost-benefit analysis, for chiropractic as a less expensive health care alternative.

THE ECONOMICS OF CHIROPRACTIC CARE

Based on size and on the number of practitioners and patient visits, chiropractic is the second largest health care service in the United States. The 23,000 practicing Doctors of Chiropractic had approximately 122.5 million patient visits in 1979, generating over \$1.3 billion in practice revenues. Chiropractors are a licensed and officially recognized health profession in all fifty states plus the District of Columbia. All fifty states authorize chiropractic services as part of their workman's compensation program. In the private sector, virtually all major commercial health and accident insurance policies provide for chiropractic services. Substantial numbers of major international, national and local unions include chiropractic services in their health and welfare plans and many industries such as General Motors, Firestone, etc. pay for chiropractic care for their employees.

The federal government has likewise recognized and authorized chiropractic services under Medicare, Medicaid, vocational rehabilitation programs, Longshoremen and Harbour Workers' Compensation Act, Internal Revenue Code (as a medical deduction). For federal employees, chiropractic services are covered under federal employees health benefits programs and in federal employees workers' compensation. Federal funding of chiropractic has also been provided under appropriation measures sent to the Department of Health and Human

Services and for a statistical survey of the chiropractic profession under the Health Manpower Act. The U.S. Department of Education officially recognized the Council on Chiropractic Education as an accrediting agency for chiropractic educational institutions.

Fueled by both government and private sector support, the demand for chiropractic services continues to grow. Evidence exists to suggest that the demand for chiropractic services far exceeds the supply. For example, in 1978 the ratio of Doctors of Chiropractic to population was approximately 10.3 per 100,000 population. The 1980 F.A.C.T.S. study, conducted and financed by the federal government, estimated that a ratio of 14.1 per 100,000 population was needed in order to satisfy existing demand for chiropractic services. Assuming the 14.1 ratio to be an appropriate standard, one Doctor of Chiropractic would be required per 7092, as opposed to the current supply of one chiropractor per 9709.

A recent study in the state of Iowa revealed that while the ratio of Doctors of Chiropractic was already 23.2 per 100,000 population in 1979, the demand for chiropractic services remained high; This suggests that the 14.1 ratio may indeed be a conservative estimate. Further indication that demand has not been satisfied comes from an annual survey by the American Chiropractic Association. In 1972, when there were approximately 15,000 chiropractors, the average number of patient visits per week was 107.1. In 1980, with a substantial growth in the number of active chiropractors, the number of patient visits per week was exactly the same (107.1), indicating an ever growing demand for chiropractic services.

The supply and demand problem is further compounded by the serious geographic maldistribution of chiropractors across the country. Ineligible for the National Health Service Corps and other health manpower programs designed to correct distribution of health practitioners, maldistribution among chiropractors is perhaps the most severe of all major health disciplines. For example, while there are 23.2 chiropractors per 100,000 population in Iowa there are .9 chiropractors per 100,000 population in the District of Columbia. The maldistribution problem is regional also. The New England States have 6.8 per cent of the nation's chiropractors while the western states compose 15.2% of the practitioners.

Chiropractors function as primary care health providers in many instances and as such play a significant role in servicing rural underserved areas of this country. Fifty-two percent of chiropractors practice in communities of less than 50,000 population. Perhaps a more telling statistic is that thirty-two percent of all chiropractors practice in areas of 24,000 or less population. It is the smaller communities that have traditionally been neglected by other health care providers. The chiropractic profession has been attempting to respond to this need.

Assessing the role of chiropractic continues to be difficult because of the lack of data on chiropractic in our health care economy. Research does suggest that chiropractic care, as compared with alternative treatment modes, can be a less costly way to treat substantially identical health problems. For example, in a study of official data from State Workman's Compensation claims, it was found

that chiropractic care was 1/3 less costly than medical care for similar ailments. A 1972 California study by C. Richard Wolf, M.D. also found that chiropractic care returned the impaired worker back to the job more rapidly than medical treatment, thus reducing business costs and increasing worker productivity.

The lack of data on chiropractic can be linked in some degree to chiropractic's exclusion from health manpower and other research and training programs. For example, the chiropractic profession has thusfar been excluded from the Department of Health and Human Services ongoing data collection activities. Yet the information such data provide is crucial not only to the future development of chiropractic, but to an assessment of its' contribution in serving the health care needs of our nation. We support reauthorization and continued funding for HHS's data collection activities in the health professions area, and we request that chiropractic be included in these activities.

The National Advisory Council on Health Professions Education also has an important role to play in assessing and developing the future role of health personnel in our health care economy. Again, despite the enormous role chiropractic has played and will continue to play in that economy, the profession has thusfar not been represented on the Council. We support reauthorization of the Council in the health manpower legislation the Committee will ultimately adopt, and urge that chiropractic be included among its members.

STUDENT ASSISTANCE

The over 8,000 students enrolled in the 15 Schools of Chiropractic recognized by the Council on Chiropractic Education must successfully complete a rigorous educational program in order to earn a Doctor of Chiropractic degree. After a minimum of two years pre-professional training (the two year requirement of professional training is similar to dental school) incorporating the prescribed content of science courses, chiropractic colleges require a minimum of four academic years of professional resident study. In addition to passing the licensing board examination in all states, the Doctor of chiropractic must pass the Basic Science Board examination: (including anatomy, physiology, pathology, bacteriology, chemistry, and public health) in four states and the District of Columbia. This is the equivalent examination given to M.D.s and D.O.s.

While the tuition and fee levels at chiropractic colleges are relatively inexpensive in comparison with other doctorate-level health professional schools, the rising costs of chiropractic education are an onerous burden which even many of our higher-income students are finding increasingly difficult to bear. Rising costs and ineligibility for health professions scholarships and loan programs have greatly skewed our student body. Despite recruitment efforts, women comprise only 17 percent of the students at chiropractic colleges, with minority groups comprising less than 1 percent. Foreign students represent approximately 4.5 percent of the student population. The disproportionate representation of the affluent in our chiropractic colleges has, of course, affected the chiropractic profession generally, which has traditionally been largely white and male.

The recent gains made by the health professions included in H.R.2004 in increasing female and minority participation is directly linked to the federal student assistance programs that have been made available to health professional students. Only through federal assistance have students in other health disciplines been able to meet the enormous costs of health educations; only through federal assistance have health professional schools been able to recruit women and minorities in increasing numbers. That the wealthy and the white remain disproportionately represented in chiropractic colleges is a testament to chiropractic's exclusion over the years from health manpower scholarship and loan programs. While our chiropractic colleges have on their own make enormous strides in this regard, lack

of financial resources have prevented them from improving to an acceptable degree the economic and racial mix of students entering the profession. All capable students, regardless of their sex, race, or family financial resources, must be allowed to pursue a chiropractic education.

We strongly support continued funding of the Health Education Assistance Loan (HEAL) and the Health Professions Student Loans (HPSL) programs, and we request that chiropractic students be allowed to compete for these funds on an equal footing with the other health disciplines. We also strongly support the program of assistance to individuals from disadvantaged backgrounds detailed in Section 220 of H.S. 2004. This program is essential if capable students from low-income backgrounds are to be able to enter the health professions. The chiropractic profession is committed to improving the income and racial mix of our students. Our inclusion in these programs is crucial to the success of that commitment.

INSTITUTIONAL ASSISTANCE

We agree with the premise of this legislation that health professional schools are a national resource that continue to bear a special responsibility in solving the health care needs of this nation. Accomplishing this goal, however, requires that schools be financially stable.

All of our chiropractic colleges are private, freestanding institutions; they are neither public institutions with the government as a primary funder nor are they parts of universities upon which

they can rely for financial support. Schools of chiropractic receive virtually no government support from either federal, state or local sources. As a result, many of our schools are fighting for financial survival. They must rely for funds solely on ongoing campaigns for philanthropic support and on tuition and fees. Tuition and fees in fact comprise nearly 70% of our colleges operating incomes, a figure sharply contrasting with the 9.9% average for the eight other health professional groups covered by federal assistance programs. These funding sources serve merely to maintain the status quo and keep chiropractic colleges solvent. Little if any of our funds remain available for special projects, improvements of facilities, continuing education, advanced clinical training, or recruitment of women and minority students.

Yet, the funding needs of our colleges are so large, and the need for new programs and improvements so great, that only through some form of additional federal support can these needs be met. Our teaching facilities are in particular need of renovation and capital improvements. Many of our colleges were constructed years ago, and are both inadequate for modern quality chiropractic education and are unable to meet the needs of a student body growing in size. Satellite clinical centers are needed to provide not only a quality clinical experience for our students, but to provide services to many of our underserved and elderly citizens who travel great distances to receive care at our present clinics. The exclusion of chiropractic from federal assistance places the profession at a serious disadvantage in the maintenance of quality education. This exclusion is neither consistent with the many federal programs which include chiropractic services, nor is it in the best interests of this country's

health care delivery system.

We therefore strongly support continued funding of the federal loan guarantees and interest subsidies programs, and we urge the Committee to allow chiropractic schools to participate on an equal basis for this federal assistance. Likewise, we support reauthorization of the financial distress grant program. Chiropractic colleges are not immune to the burden of inflation nor to the problem of maintaining accreditation in the face of steeply rising educational costs. Chiropractic colleges facing serious financial difficulty should be allowed to participate in the financial distress grant program.

We support continued funding for Area Health Education Centers (AHEC), and urge the inclusion of all health professionals, including chiropractic, in this program. The Chiropractic profession has a long history of service in underserved rural areas; the poor and the elderly have traditionally been the most dependent users of chiropractic care. Our colleges would be most anxious to initiate programs to provide needed care to the underserved and elderly who are far removed from our present clinics and teaching facilities. Lack of funding has prevented the establishment of such services in the past. Inclusion of chiropractic in AHEC would go far in both maintaining quality chiropractic education and in providing much needed services.

Testimony of the

AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

The entire osteopathic profession, including the American Osteopathic Association and the American Osteopathic Hospital Association, join us in expressing our commitment to work for an appropriate federal response to continuing health manpower needs.

INTRODUCTION

Throughout its history the osteopathic profession, represented by more than 17,000 practitioners in the United States, has worked to provide quality primary medical care. Approximately 90 percent of all osteopathic physicians are currently engaged in the delivery of primary care services, striking evidence of the significant contribution the osteopathic profession has made to meeting the national goal of making medical care available to all Americans.

In a similar manner osteopathic physicians have been instrumental in assuring access to care for persons living in geographical areas experiencing chronic health manpower shortages. The traditional emphasis of osteopathic medicine on family/general practice in the medically underserved regions of this nation is perhaps the only systematic effort in the private sector toward this goal ever undertaken. The osteopathic profession currently deploys 67 percent of its manpower in the nation's largest and smallest communities, the areas of greatest need: 50.5 percent in communities of 50,000 or less and 16.9 percent in communities of 500,000 or more.

Another area of national concern — the rising cost of health services — has likewise been a matter of importance to osteopathic physicians in terms of their practice patterns and hospital utilization. The profession's continuing emphasis on community-based ambulatory care as the preferred locus of treatment has over the years perpetuated a model of efficiency and cost-effectiveness.

In short, osteopathic medicine has had a proven record of responsiveness to national health care needs and goals long before they were articulated in terms of federal policy, and over the years has developed considerable expertise in assuring all Americans access to timely, pertinent, quality primary health care.

Many of our successes can be directly attributed to the impact of P.L. 94-484. Lacking the impetus of federal assistance, it is doubtful that our colleges could have embarked upon the dramatic development and expansion efforts necessary to address the acute geographical and specialty maldistribution problems which still characterize health care in this country. We have watched with growing frustration repeated attempts to erode or eradicate precisely that federal support which has made possible many of the most significant and effective responses by the health professions educational community to national health priorities.

It would be disingenuous of us to ignore the straitened nature of the federal budget now under consideration, or to minimize the importance of exercising selective fiscal restraint in setting federal expenditures for health professions education, as for all other aspects of the economy. However, opponents of such support are equally disingenuous in supposing that by taking the proverbial meat-ax to those programs currently funded under P.L. 94-484 significant and in some cases irreversible damage will not be done to the scope and quality of training programs. The false economy of an indiscriminate approach to fixing programs and authorizations is all too readily apparent. Not only will the functional

capabilities of the health professions schools be seriously impaired, but as tuitions are forced upward to compensate for lost federal funding, students will be driven even more deeply into debts which they will have to meet through higher patient charges. Thus, while the short-term impact of a massive retrenchment in federal assistance would disadvantage educational programs and facilities, the long-range consequences are more far-reaching, potentially affecting every health care consumer by pushing the cost of services well beyond current limits.

The following remarks highlight those programmatic and conceptual areas of particular importance to the osteopathic educational community: student financial assistance, institutional support, minority education, faculty development, and primary care training at both predoctoral and postdoctoral levels. Within the confines of this statement we have chosen not to address other provisions with which we concur, among them facilities renovation authorities and continued support for Area Health Education Centers. Nonetheless, we are fully supportive of these programs, as of the scope of H.R. 2004 as a whole, and we will be pleased to expand our remarks in any of these areas as the subcommittee may request.

I. STUDENT ASSISTANCE

Federally-supported student assistance programs have been highly successful mechanisms for assuring the availability of an adequate practitioner supply, while permitting students to enter the health manpower work force regardless of economic status. During the academic year 1979-80 nearly one-third of all osteopathic students participated in federal scholarship programs, and more than 90 percent were recipients of federally guaranteed or subsidized loans. Without such support student debt loans - and with them, health care costs - will skyrocket, and economics rather than talent will determine the composition of the student pool, to the detriment of both quality and equality of opportunity.

We advocate a pluralistic mix of scholarship, subsidized loan, and conventional loan programs of the type recommended in H.R. 2004, and are particularly supportive of the following initiatives.

A. National Health Service Corps; NHSC Scholarship Program

The National Health Service Corps and its scholarship program have been extremely effective in channeling students into geographical and specialty shortage areas while minimizing economic discrimination. Consistent with osteopathic medicine's traditional emphasis on community-based practice, a disproportionately large number of osteopathic students are currently recipients of NHSC scholarships or practicing members of the Corps; and we look to continuation of the NHSC scholarship program as a student support mechanism singularly appropriate to the practice pattern of the majority of osteopathic physicians.

However, in continuing the three-year limitation on deferrals for graduate medical students under Section 752(b)(5)(A), H.R. 2004 unwittingly perpetuates a mechanism which discriminates against osteopathic medical education. All osteopathic students are required to undertake a one-year rotating internship in addition to any residency program they may elect to pursue, thus effectively extending their graduate training to four years rather than the three common to allopathic education. The need to accommodate this unique feature of the osteopathic educational model was recently addressed through the addition of language providing for Secretarial discretion in granting deferrals exceeding three years under "The Nurse Training Amendments of 1979," P.L. 96-76, Section 202, and in Section 205(d)(1)(B) of this bill, which extends to four years the deferral option under the HEAL program. We trust that this problem can be resolved in the language of the new law rather than through post facto amendment.

B. Exceptional Financial Need Scholarships

If recruitment and retention of qualified students regardless of economic status are to register more than token gains, the EFN program must receive a realistic commitment of federal funds. We are pleased to note the inclusion of an expanded EFN program at an authorization level capable of providing adequate assistance to both needy first- and second- year students.

C. Health Professions Student Loan Program

We are highly supportive of the retention of the Health Professions Student Loan Program, the most demonstrably successful health-oriented federal loan program now in operation. This program, the most popular of the student assistance options under current law, has just begun to recapitalize on the basis of loan repayments, and early indications point to an unusually low default rate (less than 2 percent). Even without the appropriation of new monies the program is in a position to be self-supporting through the rollover of incoming repayments for new loans. The perpetuation of proven loan programs such as this one must be viewed as a priority if freedom of career choice regardless of economic status is to be assured.

D. Health Education Assistance Loan Program

Continuation of the HEAL program at borrowing ceilings consistent with actual educational cost is welcomed, as is expansion of the deferral option to four years as a mechanism for accommodating the osteopathic internship. Given current rates of interest on the open market, we predict greatly expanded utilization of this program by health professions students in the coming years.

II. INSTITUTIONAL SUPPORT

In the past Congress has provided support to institutions educating health professionals to encourage the production of additional manpower to meet national needs. These flexible, nonprogrammatic funds have been used to insure the continuity, quality, and responsiveness of health professions education to federal goals, and have been instrumental in holding tuition costs to the lowest possible level consistent with the maintenance of institutional viability. This last point is particularly important, for higher tuition will inevitably lead to higher patient care costs when students enter practice and begin to repay their educational debts. Moreover, significant tuition increases will effectively preclude disadvantaged students from entering careers in the health professions, thereby imposing discriminatory economic constraints on the composition of the practitioner pool.

With respect to osteopathic medical education there are other problems as well. Several new osteopathic colleges have arisen in response to the discrete demand for distinctively osteopathic care and the general demand for additional primary care physicians. Many of these new schools depend on institutional support to offset some portion of the unusually heavy expenses incurred during the developmental phase of an institution's life. The established osteopathic colleges are also uniquely in need of this form of assistance, for unlike most health professions schools, the majority of them are not attached to large educational complexes whose shared resources help keep operational costs to a minimum. Likewise, because our schools concentrate on preparing primary care physicians to enter practice at the earliest opportunity, their research component — and its attendant benefits relative to the acquisition of permanent facilities, faculty, and overhead offsets — is necessarily limited. These colleges rely heavily on the flexible nature of institutional support to assist them in initiating creative programs in nutrition education, patient education, remote-site training, and similar educational activities consistent with federal goals.

Our schools have been actively seeking alternative sources of income to counterbalance the expected reorientation of federal priorities away from this type of support. However, this process has been slow and, given the critical state of the American economy, too often without tangible issue. Additional time and a continued, if reduced, federal commitment to institutional funding are needed if the health professions schools are to free themselves of federal dependency in this area. We believe institutional core support should be continued, but we also realize that Congress may wish to effect significant change in both the direction and scope of such support. We therefore recommend that if the current effort is phased out as proposed in H.R. 2004, it should be replaced with a program which provides support to colleges having a proven record of producing primary care practitioners, and which encourages schools not having such a record to revise their curricula accordingly. We stand ready to work with this Subcommittee to develop a mechanism which will assure essential core support

mechanism which will assure needed core support to the nation's health professions educational institutions while simultaneously reinforcing the goal of educating more primary care practitioners to serve the needs of the American people.

III. SPECIAL PROJECTS

A. Predoctoral Training

We are pleased to note in Part D continuation of the various special project grant authorities which have been so useful to our schools in developing and augmenting their programs to meet national needs. However, we are deeply dismayed that H.R. 2004 continues to reflect the virtually exclusive preoccupation of P.L. 94-484 with postdoctoral primary care training while providing no perceptible recognition or support for predoctoral education. The osteopathic academic model is unique in that students receive the major portion of their primary care education as undergraduates, and the curriculum is largely geared to this level. By limiting the programs authorized under Sections 218 and 219 to postdoctoral activities the bill in effect penalizes osteopathic colleges for past successes in training primary care physicians under a different educational system.

In our view predoctoral education should be equally a matter of federal concern, for it is here (as the unusually large number of osteopathic physicians in primary care practice clearly demonstrates) that there exists the greatest potential to attract significant numbers of students to first-contact care and retain them as practitioners. We urge the Subcommittee to consider making specific statutory provision for predoctoral primary care programs, in addition to continuing existing support for internship and residency training. We would like to suggest three areas in which modest amendment of existing law would generate immense benefits both for predoctoral medical education and, ultimately, for the quality and availability of primary care services nationwide.

1. Faculty Development - The new primary care faculty development component under Section 218, and the proposed continuation of a similar provision under Section 786, are most welcome, for in the past federally-supported faculty development activities have been minimal. A technical amendment expanding the teaching locus for individuals trained under these authorities beyond the specified postdoctoral training programs in general internal medicine/general pediatrics and family medicine (*i.e.*, to undergraduate educational programs) will provide a greatly-needed addition to the faculty pool for medical colleges at no additional cost.

2. Remote-Site Clinical Training - While we endorse continuation of the remote-site requirement under Section 770, we are disappointed that H.R. 2004 fails to include support for clinical training. One factor responsible for our marked success in attracting and retaining practitioners in underserved communities has been the exposure of students early and repeatedly during their

clinical training to practice in remote-site ambulatory settings, yet little federal support has been available for this training modality. While remote-site training is unquestionably a cost-effective activity both in terms of providing direct services in shortage areas and developing practitioners interested in making a long term career commitment to this type of practice, it will require federal assistance if it is to continue and grow.

3. Curriculum Development - Curriculum development activities supported under Section 788(d) have proved perhaps the single most cost-beneficial program under P.L. 94-484, assuring the continued flexibility and relevance of medical education for a relatively small federal investment while helping the health professions schools expand their academic capabilities in areas relevant to national needs. Since its inception the program has generated many innovative advances in medical education and practice, despite minimal appropriations: the \$8.5 million appropriated during FY1981 for both section 788(c) and (d) barely accommodates continuation grants, and provides no support for new projects however timely or significant. Rather than continuing to tie the funding of 788 (d) activities to an umbrella authorization embracing start-up assistance and interdisciplinary training support as well in a perpetual zero-sum game, we urge the Subcommittee to create a separate authority for curriculum development, as has been done for financial distress grants (Section 788(b) of current law). In so doing this valuable program can at last achieve the solid funding base it requires to maximize its impact.

B. Minority Enrollment

We wholeheartedly endorse the increased scope and authorization for disadvantaged assistance under Section 220. Although the colleges of osteopathic medicine have been consistently supportive of special efforts directed toward disadvantaged students, the limited funding made available under this authority in the past has been insufficient to create the desired effect. This stricture is especially severe in the case of programs targeted at the attraction and retention of minority students. Particularly in the case of small schools lacking affiliation with a large university system, the availability of faculty to provide the necessary counseling, remedial, and socialization support cannot be guaranteed without increased access to the requisite funding. In the absence of one or more full-time staff members committed solely to overseeing the various aspects of the proposed program, responsibility for operating it will devolve upon staff members already overworked, with predictably dissatisfying results.

Despite chronic underfunding, programs such as the Health Careers Opportunities Program (HCOP) have managed to produce impressive results. Through a HCOP grant the American Association of Colleges of Osteopathic Medicine has established an Office of Special Opportunities (OSO) to increase the representation of ethnic disadvantaged students in colleges of osteopathic medicine. Administered in cooperation with a consortium composed of the fifteen colleges

of osteopathic medicine, the program provides a variety of services to individual schools to stimulate local initiatives such as undergraduate recruitment, summer preceptorships, pre- and post-admission academic reinforcement and peer counseling. Through the OSO a national osteopathic career information service has been made available to students, counselors, and advisors at both secondary and predoctoral levels.

A recent review of applicant and enrollment statistics for our schools indicates a significant positive demographic shift, attributable in large measure to HCOP's role in assisting osteopathic institutions to recruit and retain minority students. The percentage of minority applicants to colleges of osteopathic medicine has risen from 4.5 % in 1975 to more than 9% in 1981. First-year enrollments of minorities have likewise increased, from 5.7% in 1975 to 6.8% in 1980. The HCOP approach clearly works; but if minority recruitment and retention activities are to register more than token gains, the federal commitment must be meaningful augmented as proposed.

IV. MISCELLANEOUS ISSUES

A. National Advisory Council on Graduate Medical Education

We are pleased to see a continuation authority for this body, which has begun to issue analytical tools and paradigms of considerable utility in estimating current health manpower shortages and establishing the parameters and directions of future federally-supported health profession programs. However, we are deeply disturbed by repeated references to the allopathic Coordinating Council on Medical Education (as an *ex officio* member of the Advisory Committee (Section 712(a)(1)(A), as a consultant to the Advisory Committee (Section 712(c)(1), and as a specified contracting authority (Section 712(c)(2)) without equal attention in statutory language to the corresponding osteopathic body. Of particular concern is designation of the Chairman of the CCME as a *ex officio* member of the Advisory Committee without similar provision being made for a representative of osteopathic medical education to serve in the same capacity. We trust that this *de facto* discrimination against the osteopathic educational community is inadvertent, and that the bill will be amended to assure parity for both medical professions at this policy level.

B. Health Resources Administration Budgetary Concerns

Finally, we are compelled to raise a subsidiary issue which needs to be addressed with the context of H.R. 2004, namely the Administration's proposed reduction by more than 80% in Health Resources Administration personnel under the President's FY1982 budget proposal.

We are appalled at the magnitude of the contemplated action, which will render HRA effectively dysfunctional. There is quite simply no other federal agency capable of duplicating HRA's expertise in administering health manpower

education programs, or its knowledge of the needs and capabilities of the various participants in those programs. Nor is there an alternate locus within the Department of Health and Human Services for undertaking HRA's invaluable informational and technical assistance functions, which have been systematically and fruitfully utilized over the years not only by the health professions schools but by Congress and the Administration as well.

Most important of all, if approved by Congress the pending budget proposal will make it impossible to implement any authorizing legislation relative to health professions education which this Subcommittee may recommend, however worthy. We therefore urge you to give this matter your full and immediate attention, and to impress both upon your Congressional colleagues and Administration representatives the wholly untenable nature of such a decision.

Like our colleagues in the health professions education community, the colleges of osteopathic medicine are deeply disturbed at what is emerging as a "meat-ax" mentality on the part of some members of Congress and the Administration with regard to continued federal participation in health manpower training programs. The indiscriminate erasure of many programs, and the crippling by token funding of others, will unquestionably result in significant and in some cases irreversible damage to the scope and quality of health professions education. We therefore welcome the attempt in H.R. 2004 to preserve a comprehensive and continuing federal presence in training the individuals who will deliver health care to the American people for many years to come, and we appreciate this opportunity to lay our views before you. We will be happy to answer any questions relative to our testimony.

Walter C. Bowie, D.V.M., Ph.D.
Dean, School of Veterinary Medicine
Tuskegee Institute
Tuskegee Institute, AL 36088

Mr. Chairman and Members of the Committee:

I am Walter C. Bowie, Dean of the School of Veterinary Medicine at Tuskegee Institute, Alabama. I appreciate the opportunity to submit to the committee information on the special role of our school with respect to Title VIII of the Health Professions Educational Assistance Act of 1976.

Analysis of Tuskegee Institute's Contribution
to the Nation

Minorities, and particularly blacks, are underrepresented in the field of veterinary medicine. According to the 1980 U. S. Census, black Americans compose 12.3 percent of the population. However among veterinarians, studies by the Department of Health, Education, and Welfare (DHEW) indicated that in 1970, black Americans composed 1.3 percent of the veterinarians in the United States, approximately one-tenth of the number needed to meet parity (See Table 1--Number of Employed Veterinarians in the United States by States and Racial/Ethnic Category).

Tuskegee Institute's role in training black and other minority veterinarians has been significant. Despite being a small private school with limited state support, Tuskegee Institute, according to our own analysis of the DHEW study, had graduated 49 percent of the minority veterinarians and 93 percent of all black veterinarians in the United States.

TABLE 1

Number of Employed Veterinarians in the United States by
States and Racial/Ethnic Category:
April 1, 1970

State	Total Employed	Black	Persons of Spanish Language
UNITED STATES	19,435	252*	246
Alabama	241	9	5
Alaska	13	0	0
Arizona	169	0	8
Arkansas	171	0	0
California	2,087	13	58
Colorado	354	0	14
Connecticut	201	0	0
Delaware	19	0	0
District of Columbia	21	14	0
Florida	676	6	11
Georgia	539	10	18
Hawaii	54	0	0
Idaho	137	0	0
Illinois	902	4	0
Indiana	529	5	6
Iowa	769	3	0
Kansas	393	6	0
Kentucky	359	11	0
Louisiana	344	6	0
Maine	55	0	0
Maryland	417	12	0
Massachusetts	397	5	0
Michigan	783	0	15
Minnesota	471	23	0
Mississippi	230	22	6
Missouri	421	0	0
Montana	114	0	0
Nebraska	353	8	0
Nevada	54	0	0
New Hampshire	64	0	0
New Jersey	442	10	0
New Mexico	95	0	0
New York	1,233	24	5
North Carolina	315	6	0
North Dakota	76	0	0
Ohio	1,007	6	17
Oklahoma	329	0	0
Oregon	234	0	0
Pennsylvania	673	11	0
Rhode Island	35	0	0
South Carolina	118	0	0
South Dakota	207	0	0
Tennessee	269	5	13
Texas	1,332	14	45
Utah	86	0	0
Vermont	70	0	0
Virginia	399	19	18
Washington	501	0	7
West Virginia	92	0	0
Wisconsin	532	0	0
Wyoming	53	0	0

*252 black veterinarians are 1.3 percent of the number of total employed

SOURCE: Minorities & Women in the Health Fields. DHEW
Publication No. 79-22, October, 1978

Without Tuskegee Institute's contribution, the number of black and minority veterinarians practicing in the United States would be miniscule.

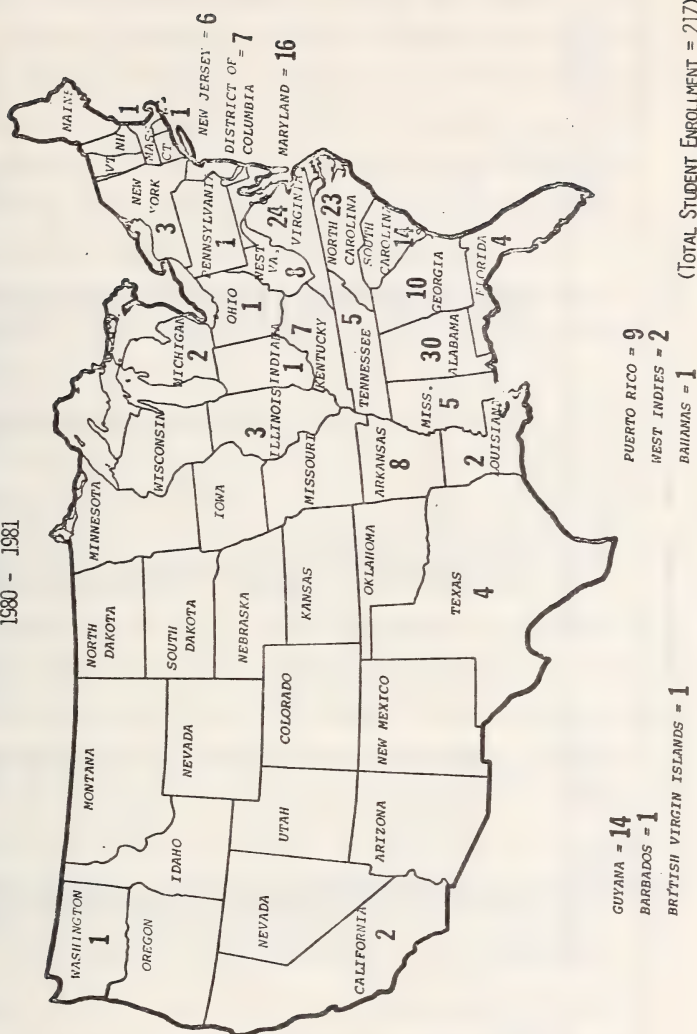
Currently, Tuskegee Institute has enrolled a remarkably heterogeneous and well-balanced student body. Twenty-six states and Puerto Rico are represented at the school (See Chart A--Geographic Distribution of Students Currently Enrolled at Tuskegee Institute School of Veterinary Medicine 1980-1981). In addition to serving a broad cross section of the United States, Tuskegee Institute has enrolled 83 percent of all foreign students studying in the United States (See Table 2--Student Enrollment of Professional Degree (D.V.M.) Students).

Tuskegee's student body is more racially integrated than any other school of veterinary medicine in the United States. Approximately 66 percent of the students are minorities. There are almost as many minority students at Tuskegee as there are at the other 25 veterinary schools combined (See Table 2--Student Enrollment of Professional Degree (D.V.M.) Students).

Tuskegee Institute's student body is evenly balanced with regard to sex. Approximately 48 percent of the student body is female, a claim relatively few other schools can make (See Table 2--Student Enrollment of Professional Degree (D.V.M.) Students).

TUSKEGEE INSTITUTE
SCHOOL OF VETERINARY MEDICINE

1980 - 1981



July 1999

2/51

TABLE 2
Student Enrollment of Professional Degree (D.V.M.) Students

School	Male		Female		Total	Foreign National	
	Caucasian	Minority	Caucasian	Minority		Male	Female
01	340	17	171	16	544		
02	256	14	195	16	481		
03	132	1	75	3	211		
04	40	72	33	71	216	15	4
05	149	2	162	6	319		
06	168	13	79	5	265		
07	77	1	36	3	117		
08	219	10	144	4	377		
09	43	0	28	1	72		
10	28	1	35	0	64		
11	43	1	47	0	91		
12	260	1	142	3	356		
13	264	5	159	2	430		
14	162	1	120	5	288		
15	309	5	221	6	541		
16	207	5	91	4	298		
17	58	0	62	0	120	2	1
18	279	14	108	7	408		
19	199	3	145	1	348		
20	313	2	153	5	473		
21	180	8	125	3	316		
22	130	0	139	0	269	1	
23	175	2	136	4	317		
24	207	3	104	2	316		
25	325	2	134	0	459		
26	243	4	207	4	458		
TOTAL	4,806	187	3,051	171	8,154	18	5

SOURCE: Comparative Data Report, 1980-1981. Association of American Veterinary Medical Colleges

The trend toward geographic, racial, and sexual balance is not recent at Tuskegee. Since its inception in 1945, the School of Veterinary Medicine at Tuskegee Institute has seen its role as serving the entire nation. Tuskegee graduates are represented in all states. Our school may be the only one which can claim that its alumni have passed state or local board examinations in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands (See Chart B--State Board Examinations Passed by Tuskegee Institute School of Veterinary Medicine Alumni). Furthermore, Tuskegee Institute graduates are concentrated in the regions of the country from which they were recruited, the underserved and impoverished regions of the country, particularly the rural areas (See Chart C--Geographic Locations of Tuskegee Institute Alumni).

From the above, it is clear that Tuskegee Institute's School of Veterinary Medicine has served the entire country--all of its states and all of its races. This mission is not a recent one; it is a historic one. Furthermore, it is a mission that Tuskegee is committed to follow in the future. This school is clearly a resource to the entire nation, and I request that you consider it so and support it appropriately.

Analysis of Tuskegee's Request from Congress

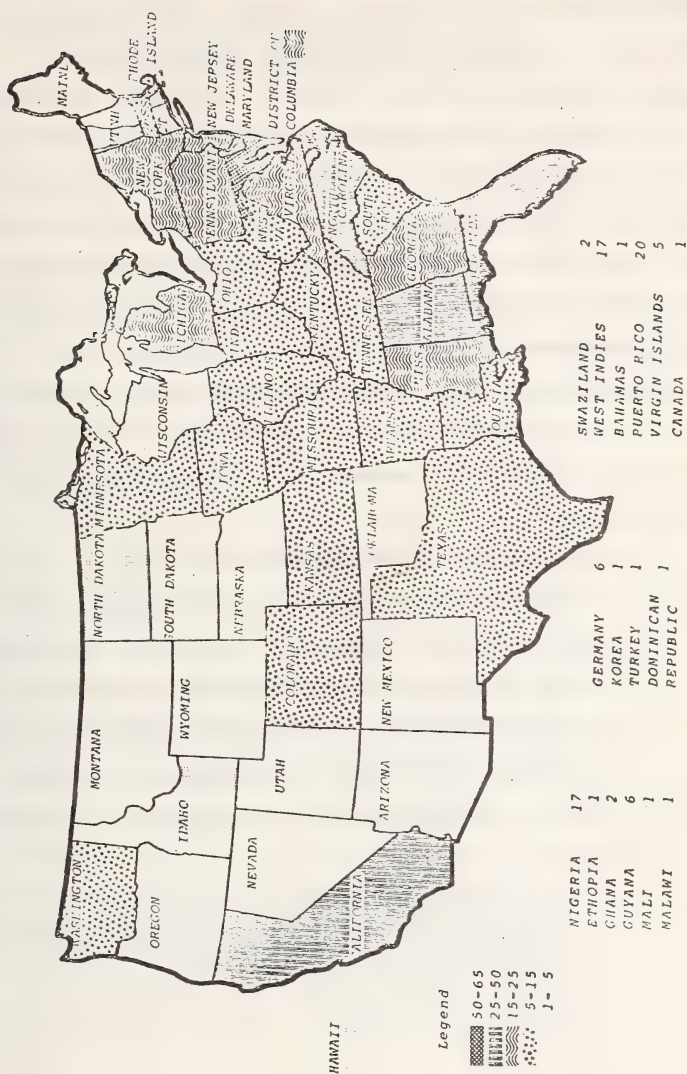
This committee has consistently recognized the problems besetting a private, minority institution which is trying to

CHART B

STATE BOARD EXAMINATIONS PASSED BY TUSKEGEE INSTITUTE SCHOOL OF VETERINARY MEDICINE ALUMNI

ALABAMA	131	MAINE	2	PUERTO RICO	14
ALASKA	4	MARYLAND	36	RHODE ISLAND	4
ARIZONA	4	MASSACHUSETTS	12	SOUTH CAROLINA	16
ARKANSAS	9	MICHIGAN	15	SOUTH DAKOTA	8
CALIFORNIA	40	MINNESOTA	8	TENNESSEE	11
COLORADO	6	MISSISSIPPI	16	TEXAS	16
CONNECTICUT	9	MISSOURI	7	UTAH	2
DELAWARE	8	MONTANA	3	VERMONT	4
DISTRICT OF COLUMBIA	24	NEBRASKA	4	VIRGINIA	35
FLORIDA	33	NEVADA	2	VIRGIN ISLANDS	2
GEORGIA	52	NEW HAMPSHIRE	4	WASHINGTON	5
HAWAII	3	NEW JERSEY	35	WEST VIRGINIA	14
IDAH0	4	NEW MEXICO	2	WISCONSIN	3
ILLINOIS	22	NEW YORK	19	WYOMING	3
INDIANA	8	NORTH CAROLINA	22	NIGERIA	3
IOWA	5	NORTH DAKOTA	6	GUYANA	1
KANSAS	11	OHIO	56	CANADA	2
KENTUCKY	18	OKLAHOMA	15	WEST INDIES	1
LOUISIANA	14	OREGON	2	BRITISH COMMONWEALTH	1
		PENNSYLVANIA	12		

GEOGRAPHIC LOCATIONS OF TUSKEGEE INSTITUTE
SCHOOL OF VETERINARY MEDICINE ALUMNI



Source-Tuskegee Institute School of Veterinary Medicine

provide professional training to students from disadvantaged backgrounds. Tuskegee has had to take extraordinary measures to identify, recruit, prepare, and retain qualified minority students. The students have experienced difficulty meeting tuition payments and living expenses. Because the institution is private, it receives limited support from the state. Faced with rising costs and greater demands to meet accreditation standards, Tuskegee has suffered from severe financial distress in each of the last few years. Our institution has met these challenges in the past and with interim federal support, will meet difficulties in the future. The nature of our federal request is broken down into the following areas.

A. Special Health Careers Opportunity

The committee recognized in its report on the Health Professions Educational Assistance and Nurse Training Amendments of 1980 that institutions of professional training have particular difficulty in identifying, recruiting, preparing, and retaining students from disadvantaged backgrounds. The report stated:

One impediment to increased enrollment of disadvantaged students is a limited pool of qualified applicants. Many students from disadvantaged backgrounds do not receive adequate preprofessional education to permit them to compete successfully in the application process.

Finally, surveys indicate that a higher percentage of students from disadvantaged backgrounds fail to complete health professions training than students from other backgrounds.

Tuskegee Institute has utilized very effectively a limited amount of funds from the Health Careers Opportunity Program to overcome these impediments with remarkable success. Through an academic reinforcement program which includes programs in pre-entry reading skills, tutorials, and multimedia self-learning, Tuskegee has managed to reverse the trends characteristic of disadvantaged students in professional training. Tuskegee has succeeded in training students who do not score well in the application process. As is apparent from Table 3 (Performance of Students as related to VAT Data), the Veterinary Aptitude Test (VAT) scores for entering students are well below the national norm. Nevertheless, this school has managed to limit the dropout rate among these students to a remarkably low figure and at graduation these students have scored above the national norm on the USDA Accreditation Examination. It is essential that the school continue to receive federal funding to continue the Health Careers Opportunity Program.

TABLE 3

PERFORMANCE OF STUDENTS AS RELATED TO VAT DATA

CLASS YEAR	NUMBER OF ENTERING STUDENTS	FIRST YEAR VAT CLASS AVERAGES	USDA ACCRED. SCORES	NUMBER OF GRADUATING SENIORS**	PERCENT OF ALL STUDENTS DROPPED	PERCENT OF CLASS BELOW 0.5 VAT %ILE (#)	PERCENT OF BELOW 0.5 %ILE DROPPED
1970	35	33.5	88.22	23	34.2	(4) 11.4	(2) 50.0
1971	36	38.7	85.96	24	33.3	(9) 25.0	(3) 33.3
1972	36	30.2	84.66	27	25.0	(7) 19.4	(1) 15.0
1973	36	13.4	86.13	24	33.3	(22) 61.0	(11) 50.0
1974	39	24.6	86.87	39	0.0	(18) 46.1	(6) 33.3
1975	42	13.1	89.5	36	14.2	(28) 67.0	(6) 21.0
1976	45	28.1	88.43	40	11.1	(15) 33.3	(3) 20.0
1977	45	25.4	90.0	40	8.8	(16) 35.5	(4) 25.0
1978	45	15.8	86.897	39	8.6	(23) 51.1	(5) 13.0

Includes Irregular Progress Students (Repeaters)

** Actual Number of Students Graduating

B. Student Assistance

The committee also recognized in its report that professional students from disadvantaged backgrounds have difficulty meeting educational expenses.

A second factor which may discourage individuals from disadvantaged backgrounds from entering careers in the health professions is the high cost of health professions training.

This is certainly true at Tuskegee. It is essential that the federal government provide support through scholarship and loans of some sort because the private lending institutions are unwilling to provide any assistance.

C. Financial Distress

Most importantly, the committee has constantly recognized the need to make grants to health professional schools in financial distress to meet the costs of operation and to carry out appropriate managerial and financial reforms. In particular the committee has seen the need to support those schools, among them Tuskegee, which have made substantial contributions toward increasing the number of minorities in the health professions even while experiencing financial distress. Tuskegee has requested in each of the last three years appropriations to meet its immediate and long-term needs over the seven-year period, 1979-1986. Our request for a special subsidy in the amount of \$1.5 million per year for this seven-year period will allow us to provide the level of program mandated by the Council on Education, American Veterinary

Medical Association, and to implement an effective comprehensive plan with sufficient maturation time to alleviate the school's financial plight, thus eliminating the need for further federal support.

The request of \$1.5 million per year will allow the school to meet the following demands:

- Meet the personnel requirements for faculty and technical staff, particularly for faculty with specialized training. Adjustments in salary and number of positions will be made using the 1980 American Veterinary Medical Association Comparative Data Summary as a guide. This adjustment in staffing and salaries is a recommendation of the accreditation report of the American Veterinary Medical Association and of the DHEW Task Force on Dire Financial Need.*
- Expend \$3.75 million in equipment and additional library holdings over the seven-year period. The school needs additional journals, both current and back issues, several abstracting services, and reference books to meet the needs of students and research faculty. According to the DHEW Task Force, the current collection is totally inadequate and sufficiently poor to jeopardize accreditation.
- Purchase scientific and medical equipment, particularly in the Veterinary Teaching Hospital and the Teaching Laboratories. According to the DHEW Task Force, the school will need \$300,000 per year over the next few years to bring it to an acceptable level in scientific, clinical, and instructional equipment.
- Strengthen the graduate program which is barely being maintained currently, and make the research program into one of truly high quality. Significant

* A Report of the Financial Needs of the School of Veterinary Medicine, Tuskegee Institute, Tuskegee Institute, Alabama, for the Seven-Year Period 1977-78 to 1983-84, HRA, DHEW, January 15, 1979.

implementation of such programs, however, would require the aforementioned support for faculty, staff, library, and equipment, as well as additional stipend support for graduate students and research funds for scientific research proposals.

The above request for a seven-year period of support will permit the proposed plan for financial solvency to develop. Such a plan includes the identification of replacement funds for federal support that the school is now receiving. The school expects to generate replacement support at the end of the seven-year period through increased student enrollments, increased levels of tuition and fees, additional Southern Regional Education Board contracts or other state contracts, corporation and foundation grants, the Institute's Centennial Campaign which includes a \$2 million endowment for veterinary medicine, research support, and additional hospital income resulting from the provision of expanded medical services.

Furthermore, even though the school will probably follow a trend of deficit spending through 1983, it should be able to reverse this trend in the year that follows. According to the DHEW Task Force Report, there will be a substantial reduction in spending after 1983 due to several factors. The physical plant construction and renovation will be complete, the initial complement of equipment

will be acquired, the curriculum changes will be stabilized, the Learning Resources Center will be fully staffed, equipped and generating revenue, and the teaching hospital will not be operating at a deficit.

In summary, the School of Veterinary Medicine is financially dependent upon the federal government for the present to supplement other sources of support that are available to the institution if the school is to continue to carry out its mandate to train minority health professionals. The support must be in three areas: academic reinforcement, student assistance, and support for institutions in financial distress.

The school has met and will continue to meet the needs of a segment of society which has been traditionally neglected. Tuskegee's success in achieving this mission is reflected in a passage from the DHEW Task Force Report.

There is an enthusiasm for the school and its student body that may well be unique among other schools of veterinary medicine. The student body is most impressive. Most veterinary faculty members would find it difficult to believe that these students could be successful under any circumstances. To see them becoming successful is a rewarding experience. To sense their enthusiasm and dedication to the mission of the institution, their support for their faculty and themselves, and their dedication to excellence is a moving and unforgettable experience.

STATEMENT OF RAY DENISON, DIRECTOR, LEGISLATIVE DEPARTMENT
AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS
BEFORE THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
HOUSE COMMITTEE ON ENERGY AND COMMERCE
ON H.R. 2480 AND H.R. 2550,
HEALTH MAINTENANCE ORGANIZATION AMENDMENTS

April 3, 1981

The AFL-CIO appreciates the opportunity to comment on
H.R. 2480 and H.R. 2550.

These bills would extend the Health Maintenance Act for
another three years. However, grants to start new additional
Health Maintenance Organizations would be terminated. HMOs
that have entered into their planning and development stages
would still be eligible for grants or loans to permit them to
complete their development and become operational.

The loan program would be continued so that new plans would
be able to cover their initial operating losses until they had a
sufficient number of enrollees to operate without further federal
financial support.

It is the position of the Administration that HMOs have
demonstrated their ability to provide quality health services
effectively and efficiently and that, therefore, they no longer
need federal support. Private investment capital, it is alleged,
will be able to finance the expansion of existing plans and the
development of new ones.

The AFL-CIO disagrees with this assessment. Private capital
expects a return on its investment. Therefore, to rely on the
private sector to provide funds for HMOs is to invite an emphasis
on profits which is often at odds with the need to provide quality
health care in an effective and humane manner.

It is for this reason that the AFL-CIO is greatly concerned about phasing out federal involvement in the development of new HMOs. H.R. 2480 does provide planning and development grants to non-profit HMOs that have begun their funding cycle and are in the pipeline. H.R. 2550 only provides loans for this purpose. The AFL-CIO, therefore, strongly prefers H.R. 2480 in this respect. However, a forced abandonment of promising, developing HMOs would be a tragic waste of federal funds already expended were the program to be abruptly terminated. Similarly, while we also endorse the related extension of the federal loan program to cover the initial deficits of new operational HMOs, we oppose loans to for-profit HMOs.

While there have been few bankruptcies of federally funded HMOs, there have been some. We, therefore, favor a set aside of some portion of future loans to protect HMO members from the claims of providers in the event of insolvency in the future.

Two features of the law have created a favorable climate for HMO development. They are Section 1311 of the Act (which overrides state restrictive laws) and Section 1310 (the "dual choice" provision in the HMO act, which has provided market access for HMOs among employee groups).

Actually, "dual choice" is a misnomer since employers are required to offer their employees an Independent Practitioners Association as well as a Prepaid Group Practice Plan, if requested, in addition to a conventional insurance plan. In reality, therefore, "dual choice" is really "triple choice." We note both bills would extend triple choice even further by requiring employers

with more than 500 employees to offer more than three if requested by another HMO. The AFL-CIO strongly opposes this change because of its mandatory feature and because the offering of a multitude of HMOs will inevitably be confusing to workers. Where an additional HMO serves an area in which a substantial number of employees of a particular employer reside, it can be provided as an option by voluntary agreement of the parties involved: the employer, the union and the HMO.

If federal financial assistance for new HMOs is phased out, it is essential that the regulatory structure underlying the dual choice provision be continued. Under present law, an HMO must be approved by the union before it can be offered to the individual employee. Neither the union, the company nor the employees have the expertise to judge the quality of care the HMO provides. The federal qualification process, including site visits, provides our affiliates and our members with the assurance necessary for them to encourage participation and influence the individual's decision to join or not to join. It is essential, therefore, that the regulatory functions with respect to dual choice and qualification continue to be performed by the Office of Health Maintenance Organizations after funding of the program has been phased out. It is also essential that OHMO have sufficient appropriations to perform these tasks effectively. We, therefore, strongly oppose the provisions of H.R. 2550 which would repeal the program evaluation and annual report requirements of present law.

Both bills would reduce the scope of mandatory or required services as a condition of qualification. They propose to reduce required services to those essential for the delivery of physical health services and make mental health services, including alcoholism and drug abuse, an optional benefit. We favor this change. Many of our health and welfare plans do not provide coverage for mental health. To require HMOs only to provide mental health care and not traditional insurance plans would put HMOs at a competitive disadvantage.

H.R. 2480 would continue funding for technical assistance. Putting together an HMO is a difficult and complex task. Therefore, funding for technical assistance is an essential part of developing and operating a new HMO. Paradoxically, however, H.R. 2480 deletes the management training provision of the present Act. In this respect H.R. 2550 is preferable since the bill authorizes funds for the National Health Maintenance Organization Intern program and for technical assistance.

Both bills have provisions the AFL-CIO strongly opposes. One deletes the requirement in present law that one-third of the members of the HMO's governing board must be subscribers of the plan. While a number of HMOs have a member advisory council, such councils provide linkages between subscribers and consumer board members to increase their effectiveness. Advisory councils alone are not enough. Board membership is the most meaningful means of subscriber input.

Disastrous in its implications is the proposed deletion of the community rating requirement in present law. HMOs can

provide health services from 10 to 40 percent less expensively than the fee-for-service system. HMOs can, therefore, effectively compete with experience rated plans for the great majority of employee groups. There are sound business as well as social reasons for continuing the community rating requirement.

Community rating has been a distinguishing characteristic of HMOs for many years, primarily because it is the rating system most compatible with their budgeting system. By basing their rates on the utilization of health services by the entire population served, the cost of providing care is spread to high risk groups. At the same time, stability of revenues is achieved. This permits the HMO to formulate budget projections with sufficient certainty to plan for physician compensation, facilities expansion and administrative costs.

Because they are providers as well as insurers of health care, fluctuations in revenues cause difficulties for HMOs in meeting their financial and service commitments.

A small, growing HMO pressured to experience rate a large employee group must still generate enough revenue from other accounts to cover administration and marketing costs. Thus, because of its compatibility with the HMOs' budgeting system, community rating is of positive value to HMOs as competitors in the market place.

Unfortunately, H.R. 2480 would allow HMOs to determine rates on a per class basis where the classes are established on the basis of age, sex, marital status or family size. Rates

established in this manner should deceive no one. They would be a prospective estimate of what the actual experience would be. No doubt, each year the factors would be adjusted if, by bad luck, the prospective estimate differed from the actual experience retrospectively. Make no mistake about it.

H.R. 2480 would eliminate community rating. The AFL-CIO urges the wording of the present act be retained as provided in H.R. 2550.

The authority for ambulatory facilities construction loans would be repealed by both bills. The Prepaid Group Practice form of HMO requires an outpatient health center as well as medical staff to operate. The proposed omission would impose an unreasonable additional cost on PPGPs and make them less competitive.

Lastly, we oppose the repeal of provisions in the present Act that give special consideration in the granting of assistance to HMOs that serve medically underserved areas.

H.R. 2480 and H.R. 2550 should allow the continuing growth of HMOs over the next three years. The AFL-CIO appreciates the opportunity of expressing its views.

AMERICAN DENTAL HYGIENISTS' ASSOCIATION

WASHINGTON, D.C. OFFICE
1101 17TH STREET N.W.
SUITE 1006
WASHINGTON, D.C. 20036
(202) 833-3024

March 9, 1981

The Honorable Henry A. Waxman
House of Representatives
Committee on Energy and Commerce
Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Waxman:

The American Dental Hygienists' Association wishes to be on record with the House Energy and Commerce Health Subcommittee as supporting the provisions of your new health manpower bill, the "Health Professions Educational Assistance and Nurse Training Amendments of 1981" (H.R. 2004), introduced in the House of Representatives on February 23, 1981.

This letter will offer comments and suggestions on specific sections of H.R. 2004. Renewal of the legislative authority for the Health Professions Educational Assistance Act of 1976 (P.L. 94-484) is one of the highest priorities among the Association's 1981 legislative goals. Accordingly, the Association commends you and your colleagues in the House of Representatives for taking the initiative to continue federal support for the health professions education and training programs into the 1980's.

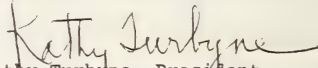
On the basis of informal estimates, ADHA has determined that the federal government has already invested over \$7 billion in providing assistance to health professions schools and training centers since Congress passed the first health manpower bill in 1963 (P.L. 88-129) and the Allied Health Professions Personnel Training Act of 1966 (P.L. 89-751). Thus, for more than sixteen years, Congress has demonstrated its conviction that health professions and allied health professions schools and training centers are an important national resource needed to assure that health and allied health professionals are available in adequate supply to provide high quality health care to the nation's citizens.

The Association believes that the quid pro quo of the federal/private sector partnership on health manpower programs and issues, through the years of such legislation, has been effective and mutually productive and beneficial. Some of the national goals initially determined have already been attained; however, there are still unmet and unresolved goals to be addressed, such as, improving access to and availability of health care to unreached and special population groups.

The Association applauds the Subcommittee's efforts to continue to modify the current health manpower programs in accordance with envisioned needs and to extend support for the educational institutions and agencies of the health professions. Our comments on H.R. 2004 follow, as enclosure #1.

We respectfully request that this letter, with its enclosure, be included on the record of the March, 1981 Subcommittee hearings.

Very sincerely,

A handwritten signature in cursive script that reads "Kathy Turbyne".

Kathy Turbyne, President
American Dental Hygienists'
Association

BFM:kjr

Enclosures

cc: Members of the House Energy and Commerce Subcommittee on Health

AMERICAN DENTAL HYGIENISTS' ASSOCIATION

Comments on Health Professions Educational Assistance and
Nurse Training Amendments of 1981 (H.R. 2004)"Title II - Health Professions Programs Under Title VII"Part C - Section 770. Institutional Support GrantsComments

ADHA is opposed to the termination of institutional educational assistance grants at this time. The authorization levels recommended in Section 770 (d) (3) in H.R. 2004 for FY 1982-1984 appear to represent reasonable appropriations' targets for the dental educational institutions to maintain the quality of their curriculums and faculties as established under previous health manpower legislation. Also, the Association concurs with the sponsors of H.R. 2004 that annual enrollment increases, as a means test for eligibility for federal assistance, are no longer necessary.

Part D - Section 217. Project Grants and Contracts;
Physician Assistants and Dental AuxiliariesComments

The Association has supported the inclusion of EFDA grants in previous health manpower laws and firmly believes that this title of a new law should be retained as it is in H.R. 2004. However, in view of the Comptroller General's Report on "Increased Use of Expanded Function Dental Auxiliaries Would Benefit Consumers, Dentists and Tax Payers", March 17, 1980, the Subcommittee may wish to consider the need to establish a separate authorization for EFDA training. If Congress determines that the Comptroller General's recommendations should be implemented within the federally funded dental care delivery system, EFDA training programs will become significantly more important in the overall effort to improve the efficiency of the dental component of the nation's health care delivery system. The Association recommends that authorizations for EFDA training programs be as follows: \$5,000,000 for fiscal year ending September 30, 1982; \$6,000,000 for the fiscal year ending September 30, 1983; and \$7,000,000 for the fiscal year ending September 30, 1984. In addition, the Association urges that the EFDA grants program be funded separately from the Physician Assistants grants program in order to clearly reflect the intent of Congress.

Enclosure number one

Section 794. Midcareer Training and EducationComments

The Association supports this section of H.R. 2004 which it recognizes as an innovative health manpower concept that logically arises from previous health manpower program initiatives. If implemented, the Association urges the Subcommittee to include allied health training centers, in university settings, as possible sites in which advanced training in health systems financial management and health care strategies could be offered.

Section 794 C. Grants to Departments of Preventive or Community Medicine or DentistryComments

The Association supports the intent of H.R. 2004 to provide incentives for dental and medical schools to establish departments of preventive dentistry and medicine to coordinate pre-doctoral and post-doctoral courses. While many of the schools have already established preventive and community health departments in their curriculums, the coordination and integration of preventive approaches to health care do need to be interwoven with instruction offered in other major departments. Since dental hygiene education is primarily prevention oriented, dental hygiene departments of dental schools will be an important resource for the dental educators to utilize in designing new programs to qualify for assistance under Section 794 C.

The American Dental Hygienists' Association supports the proposal to establish preventive and community dental health departments in dental schools and recommends that the authorizations for this special project program outlined in H.R. 2004 be increased to \$4,000,000, \$5,000,000, and \$6,000,000 in FY 1982, 1983 and 1984. It is further recommended that these sums be divided equally between dental and medical schools on a first-come, first-served basis.

Part F - Allied Health Personnel. Section 235, Project Grants, Section 236, Traineeships and Section 237, Educational Assistance for DisadvantagedComments

The Association, as one of the allied health professions designated in the original Allied Health Professions Personnel Training Act of

1966 (P.L. 89-751), strongly supports the continued inclusion of an allied health authority in the amendments to P.L. 94-484. Despite efforts of the Executive Branch in recent years to terminate this program, ADHA does not believe that the need for continued support of allied health training centers and programs has diminished. H.R. 2004 recognizes the need to provide continued support for allied health educational institutions.

We urge the House Commerce Subcommittee on Health to hold firm in its intention to support allied health education and training at least at the levels proposed in Sections 235, 236 and 237 of H.R. 2004. While this level of support does not seem to be adequate to meet the needs for federal support of the schools of allied health, the Association recognizes the severity of pressures currently to stay within the Congressional budgetary limits which are widely known and understood.



American Psychiatric Association

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March 10, 1981

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Honorable Henry A. Waxman
Chairman
Committee on Energy and Commerce
Subcommittee on Health and the
Environment
2424 Rayburn House Office Building
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

The American Psychiatric Association, a medical specialty society representing approximately 26,000 psychiatrists nationwide, is pleased to have the opportunity to submit the following statement and fact sheets during your consideration of H.R. 2004 and to expand upon the critical issues affecting psychiatric education and the supply and demand for psychiatric services.

Our testimony presented to your subcommittee last year during the consideration of H.R. 6802 similar to the cited bill, H.R. 2004, is attached as part of our statement. We believe it essential to reiterate the theme of that statement: There is a severe shortage of adult and child psychiatrists which current health professions educational assistance and reimbursement mechanisms are not addressing adequately either vis a vis other specialties or independent of other specialties.

Since our 1980 statement was presented, the GMENAC final report was issued which contains 1990 projections of shortages of 8,000 adult psychiatrists and 4,900 child psychiatrists. These GMENAC projections reinforce similar shortage projections by ADAMHA, Rand Corporation, and the Heritage Foundation.

During your consideration of H.R. 2004, the APA urges the Subcommittee to give the psychiatric needs of Americans equitable legislative consideration and treatment, and not emphasize one shortage specialty to the denigration of others.

We also are hopeful that initiatives in the area of reimbursement, particularly under Medicare and Medicaid, will be approved which would bring psychiatric coverage on par with that of general medical care.

We trust that the attached summary of cost-effectiveness studies on the inclusion of psychiatric benefits, will allow us to begin a process through which you and your Committee and staff will share our belief that when mental illness coverage parallels that

of other medical care, cost-effectiveness will result.

We welcome the opportunity of continuing to work with you to respond to the discrimination against millions of Americans who have been identified as in need of medical treatment of mental illness. For example, two million individuals have been or would be diagnosed as schizophrenic; two million suffer from profound depressive disorders; two million suffer from profound depressive disorders; and more than one million have organic psychoses of toxic or neurologic origin and other permanent disabling mental conditions. Indeed, more than 25 percent of elderly persons diagnosed as "senile" actually have a diagnosable, treatable, and often reversible mental disorder; they need not be written off or forgotten by society.

We would appreciate if all of this material, including facts sheets on NIMH appropriations needs and health professions educational assistance, would be made part of the hearing record for H.R. 2004.

Please let me know if we can be of assistance.

Sincerely,

Melvin Sabshin, M.D.

Melvin Sabshin, M.D.
Medical Director

MS:RC:aw

Enclosures: Cost-effectiveness Summary
1980 Statement
HPEA Fact Sheet
Appropriation Fact Sheet

cc: Members, Health and Environment
Subcommittee

STATEMENT OF
THE AMERICAN PSYCHIATRIC ASSOCIATION
and
THE AMERICAN ACADEMY OF CHILD PSYCHIATRY

The American Psychiatric Association (APA), a medical specialty society representing over 25,000 psychiatrists nationwide, and the American Academy of Child Psychiatry (AACP), representing 2,300 psychiatrists who have completed two years of additional training in child psychiatry, submit the following statement in regard to consideration of Federal health manpower legislation by the Subcommittee on Health and Environment of the Interstate and Foreign Commerce Committee of the U.S. House of Representatives.*

At the outset, the APA wishes to express its strong support with respect to the critical need for the development of Congressional findings which designate psychiatry as a medical shortage specialty. We believe such recognition will encourage more individuals to select psychiatry as a career and provide the needed psychological reinforcement to demonstrate both concern and reality.

During your Committee's consideration of the Nurse Training Act (H.R. 3633) in the first session of the 96th Congress, data was submitted to each member of the Interstate and Foreign Commerce Committee which articulated the reasons justifying such findings. At such time the Committee expressed the view that such designation best be considered during deliberations on renewal of the health manpower act. Accordingly, we now submit for your consideration the recommendation set forth in our March 15, 1979 statement:

"As you know one of the President's Commission on Mental Health major recommendations was:

"The Health Professions Educational Assistance Act be amended to designate psychiatry as a medical shortage specialty and require medical schools to set aside a certain proportion of their residency positions for this discipline."

*Whenever "APA" is mentioned, such mention is intended to include the AACP.

The present statement will focus upon the scope and dimensions of America's mental illness problem and what the APA believes should be the response to those problems through Federal health manpower legislation. The statement will also provide further support for the above-cited legislative determination that psychiatry is a medical shortage specialty.

There are as many as 20 to 32 million citizens of this country identified by the President's Commission on Mental Health as in need of treatment for mental illness. We are speaking of two million individuals who have been or would be diagnosed as schizophrenic; two million who suffer from profound depressive disorders; more than one million with organic psychoses of toxic or neurologic origin and other permanent disabling mental conditions. More than 25 percent of those elderly persons diagnosed as "senile" actually have a diagnosable, and if treatable, reversible, mental disorder, and need not be forgotten, or written off by society as lost. The number of children in need of immediate psychiatric intervention is conservatively estimated by the AACAP at 5 million.

Yet, the evidence with respect to the numbers of psychiatrists available to provide medical/psychiatric care for these millions of Americans, emphasizes that there is a serious shortage. For example, the FY 1980 Senate Appropriations Committee Report expressed the following concern:

"The Committee continues to be concerned about shortages of trained psychiatrists, psychologists, psychiatric social workers and psychiatric nurses. The shortfall in personnel across the four core disciplines is most severe for psychiatry because of a rising utilization rate and a decline in the supply of both United States and foreign medical graduates in the field of psychiatry. Figures provided the Committee show that in fiscal 1980 alone there will be a shortfall of 10,000 psychiatrists and that this shortfall will increase further in the 1980s."

The FY 1981 House and Senate Labor-HEW Appropriations Subcommittee in ADAMHA hearings again expressed concern about the shortage and implored the Administration to explain how the needs of the mentally ill can be met with a static training budget. The Administration's response indicated shortage estimates for psychiatrists ranged from 10,000 to 60,000.

In the exchange between members of Congress and representatives of ADAMHA, NIMH and Secretary Harris' office regarding FY 1981 clinical manpower training funds, the response really was not whether there is a shortage, but how large it is.

A factor which had an impact on this shortage was the implementation of P.L. 94-484 which reduced the number of FMGs who could train and remain in this country. Many of these FMGs trained as psychiatrists. The APA believes that this country has the responsibility to meet its own psychiatric needs with qualified physicians and that it should not endorse or maintain policies which create a "brain drain" on foreign countries.

Further, we suggest that this nation's medical education policies should not emphasize or enhance the attractiveness of one shortage specialty, such as primary care, without analyzing the impact this emphasis will have on another shortage specialty, such as psychiatry. We endorse the support given primary care for, as you know, at least 35 percent of mental conditions are first detected by primary care physicians, but liaison psychiatry is an important concept which the pending legislation needs to develop further. Liaison psychiatry programs and activities for nonpsychiatric physicians (primary care and other medical specialties) provide education, training and assistance to such physicians by psychiatrists in the biopsychosocial aspects of medical care using the existing medical setting and patient. What is needed, however, is an equivalent commitment to recruit, train and place adequate numbers of psychiatrists to meet the varied needs and goals articulated in the President's Commission on Mental Health, its implementing task forces, and the shortage, estimated by GMENAC and acknowledged by NIMH. It will take interagency cooperation among ADAMHA, HRA, HSA, HUD, VA, DoD and others, to address this problem comprehensively.

A study of expressions of career preference among individuals who took the 1977-78 Medical College Admission Test (MCAT) was shown to reflect actual career choice. There was a 28 percent drop from 1976-77 to 1977-78 in individuals expressing a preference for psychiatry. Of the pool of applicants, only those expressing a preference in family medicine increased

(from 25 percent to 35 percent in the same one-year period). The 1976 health manpower law, P.L. 94-484, was signed October 12, 1976, and the new provisions took effect October 1, 1977. This law strongly expressed Congressional recognition of the shortage of primary care physicians. Such statutory recognition had an instantaneous impact on those students who were deciding on becoming physicians. Likewise, with no concomitant expression about psychiatry, the opposite result occurred, despite data on need and utilization and projections relating to reductions in psychiatric FMGs.

While the law did create the opportunity for criteria for the designation of psychiatric manpower shortage areas under Section 332, and it was estimated that by the end of 1979, 1,200 psychiatric shortage areas would be designated pursuant to such criteria, currently there are only approximately 160 designated psychiatric shortage areas and there are only 13 psychiatrists in the National Health Service Corps.

Only late last year did the Health Resources Administration (HRA) amend the scholarship program selection criteria to give students interested in psychiatry "category one" preference (equal to that for primary care) for scholarship selection. Also noteworthy is the deplorable and inexcusable paucity of mention of the training needs of psychiatrists and the service needs for such psychiatrists in the recently released HRA publication, "Report on Health Personnel in the United States". For instance, even though there were specific designation criteria for psychiatry published in the January 10, 1978 Federal Register, the HRA publication does not either in a table or in the narrative discuss the number of psychiatric health manpower shortage areas or psychiatrists needed as of October 31, 1978, despite the fact that every other type of shortage area was displayed in the table. We note from this report that as many as one-eighth of our population resides in medically underserved areas. Moreover, the report further indicates that increasing emphasis should be placed on the needs of a population which is growing older and fraught with increasing numbers of chronic conditions. This is a population with significantly greater mental health needs. We note that the report does not raise similar concerns with respect to the mental health problems confronting our nation's population, including children and adolescents.

Congressional deliberations on the renewal of the Nurse Training Act, resulted in the law being amended to delete the three-year maximum deferment a physician could receive before he or she would be required to perform obligated service in the National Health Service Corps or Indian Health Service. Since psychiatric residencies are at least four years in length, the three-year limit clearly discriminated against psychiatric residents--not to mention psychiatric needs of the NHSC, PHS and IHS. The APA is gratified that this provision will be retained and recommends that it be authorized for other programs such as the Health Education Assistance Loan (HEAL) program.

Also, we would recommend that medical students who are preparing to become primary care physicians should receive substantial training in the biopsychosocial aspects of patient care. They then would have sufficient ability to diagnose, treat or refer, when appropriate, for mental illness. In 1976, it was estimated that 43.6 percent of persons diagnosed as having a mental disorder are treated in the general medical sector. There is a demonstrated need, therefore, for strong liaison psychiatry education in medical schools and in general residency training programs to ensure that primary care physicians will have the most appropriate tools to recognize, treat, or refer, when appropriate, those patients with mental disorders which are masked by or accompanied with physical symptoms. We would encourage the statutory inclusion of biopsychosocial aspects of medical patient care in all primary care training sections.

Further, Section 788(d) of current law contains authority to fund health manpower projects and programs such as "cooperative human behavior and psychiatry in medical and dental education and practice" (Section 788(d)(4)) and "training in the diagnosis, treatment and prevention of the diseases and related medical and behavioral problems of the aged" (Section 788(d)(21)). These programs, because of the potential they offer to address the joint presentation of physical and mental illness, should be retained. We have already discussed the essential nature of liaison psychiatry. With reference to the aged, the President's Commission on Mental Health, among other entities, has cited the cost-effectiveness of providing mental illness coverage for the aged. Therefore, training in geriatric psychiatry also would be cost effective.

With respect to provisions regarding reimbursement policies, the APA is supportive of Title V of H.R. 6802 which would revise Medicare and Medicaid reimbursement policies relating to primary care residency programs. However, we would recommend that such Title should be amended to include psychiatric residency programs and psychiatric outpatient/ambulatory care facilities, particularly because psychiatry is not a technology-oriented specialty, but a time-based specialty and has increasingly emphasized ambulatory care, prevention, and early intervention. We would welcome the opportunity to provide you with any additional information that you may require to support our suggested amendment to revise reimbursement policies for psychiatric residency programs.

Other APA specific amendments to H.R. 6800 and H.R. 6802 we submit for your consideration follow.

Additional Recommendations for H.R. 6800 & H.R. 6802

The APA supports the modifications H.R. 6802 makes to the National Health Service Corps Program and has specific additional recommendations:

(1) Subsection (g) of Section 333 (page 7 of H.R. 6802) should be amended further at lines 10 and 16 to include "and psychiatric services" after "primary health care" so that improvements in the assignment of members of the Corps to health manpower shortage areas can address the medical specialty of psychiatry for which there currently are shortage area designation criteria and service delivery needs.

(2) The number of awards to certain specialties/disciplines which data indicate are in particular shortage receive an increased percentage of scholarships until the shortage is in closer relationship to needs for other specialties/disciplines.

(3) The NHSC should become more active and proactive in informing communities of apparent underservice and offer designation and corps site development and technical assistance to them. We therefore endorse Section

337 of H.R. 6802, but would recommend report language which would emphasize the primary care and psychiatric service needs of underserved populations.

(4) The NHSC should designate all health manpower shortage areas as soon as possible and award scholarships to the appropriate specialties/disciplines in proportion to the future need for such specialties/disciplines unless the Secretary has clear and convincing evidence that such shortage can be alleviated by some other specific Federal, state, local or marketplace mechanism(s).

(5) That Section 332(d), relating to designation of health manpower shortage areas be amended by adding at the end thereof the following:

(a) On page 5 of H.R. 6802, insert: "Priority for designation or assignment will be given to specialties/disciplines for which shortages have been determined by the Congress or the Secretary. Recruitment and assignment shall be made in relation to the future needs of such specialties/disciplines, as determined by the Secretary, unless the Secretary has clear and convincing evidence that such shortage can be alleviated by some other Federal, State, local or marketplace mechanisms. Assignment of such individuals from specialties/disciplines with such characteristics are to be made at a higher rate than the eventual need for such specialty/discipline until the shortage for such specialty/discipline is in closer relationship to the needs for other specialties/disciplines".

(6) The APA believes the 81% set aside for medical and osteopathic students has worked well and does not believe its elimination as proposed to be appropriate.

(7) The APA believes that the authorization levels for the NHSC Scholarship Program are inadequate and do not incorporate inflation or nominal growth factors.

The APA is pleased by H.R. 6802's amendments for the Health Education Assistance Loan (HEAL) program, but recommends that the three year program deferral provisions be extended appropriately and not continue to discriminate against individuals seeking to become general or child psychiatrists, four and five year residency programs. In addition to the aforementioned recent data on general psychiatrists, recent data indicate that there is a severe shortage of child psychiatrists. The present production of 200 child psychiatrists yearly is barely adequate to maintain the current force of 3,000 child psychiatrists, and does not address any of the problems of shortage, which GMENAC is expected to project at 30,000.

We therefore would recommend that Section 731(a)(2)(C) of H.R. 6802 make provisions for residencies extending beyond three years which individuals in specialties and subspecialties determined by the Secretary to be in short supply. The APA also believes that an NHSC and Armed Forces Scholarship recipient should not be excluded from obtaining HEAL program funds, as proposed in S. 2375, because there may be circumstances which would make these additional funds essential for a student to continue to pursue a health professions education.

With regard to the First Year Scholarship Program for Students of Exceptional Financial Need (EFN), we endorse the change in the amount of the scholarship proposed by S.2375. We would hope that more students would be able to benefit from the program. Further, we would endorse the expansion of this program. Further, we would endorse the expansion of this program to a two-year program, and would also like to see the current definition of EFN revised so that a larger number of "needy" students could be included. We further urge that awards be made to such students who demonstrate interest in or commitment to complete programs in specialties or disciplines with the greatest shortage and/or maldistributions problems, and that awards not necessarily be made to all schools, consistent with the amendment in H.R. 6802.

The APA supports the continuation of the Health Professions Student Loan Program in view of its success and acceptance by both students and their institutions. We believe that Section 741(f)(1)(B) should be amended to allow all educational debts, evidenced by written agreements, to be eligible for repayment. This recommendation would require the phrase "entered into

before October 12, 1976" to be deleted.' This change would create larger incentives for physicians to agree to practice in shortages areas.

With respect to institutional support, the APA believes that any concept which emerges from the Congress must respond to the need to have a diversity of physicians who, by specialty and in the aggregate, can deliver high quality medical care to the population consistent with identified needs and accordingly recommend that the institutional support sections (Sections 770, 771 and 772) provide mechanisms to enhance the training of medical students who ultimately will choose a career in psychiatry and other shortage specialties. Further, these Sections should include provisions that all students (particularly those in primary care) receive substantial instruction in the biopsychosocial aspects of patient care, including prevention.

We recommend that Section 787, "Educational Assistance to Individuals From Disadvantaged Backgrounds," (and similarly in S. 2144 in Section 755), be modified to articulate the need, whenever possible, to identify, recruit and select individuals from underrepresented minority groups or disadvantaged backgrounds to become physician specialists in shortage specialties such as primary care and psychiatry.

With reference to the various Special Projects proposals, the APA encourages the modification of all appropriate authorities to ensure that emphasis be given to projects which could support and enhance the education and training of psychiatrists and other shortage specialists so that ultimately the services of these physicians could be delivered consistent with the health care needs of the population. For example, psychiatry curricula should be enhanced at medical and osteopathic schools in order to increase the likelihood that more students will choose a career in the shortage specialties of general and child psychiatry, as well as be more skilled, knowledgeable, in the biopsychosocial aspects of patient care.

The Area Health Education Centers (AHEC) Program has been and should continue to be a useful initiative. We are pleased to see this activity continued in H.R. 6802, with the requirement that there be active participation of individuals associated with departments of psychiatry. This

incorporation is vital to ensure adequate exposure of medical students to biopsychosocial aspects of patient care so that they will be trained to diagnose, treat when appropriate, and refer when indicated, patients with mental disorders. We note, however, the requirement in Section 781(d)(2)(B) that each AHEC "assess the health manpower needs of the area served by the center (in coordination with the activities of the local health systems agency or agencies relating to such health manpower needs of the area) and assist in the planning and development of training to meet such needs."

However, this provision does not contain authority which would allow for the support of the provision for conduct of medical residency training programs at such AHEC in specialties other than family medicine, general internal medicine or general pediatrics, if health manpower needs were determined to exist in specialties other than those just noted.

Because of the ambulatory nature of psychiatric residency training, the documented shortage of psychiatrists, and the existence of psychiatric shortage areas and designation criteria, it is very likely that an AHEC would determine that, in accordance with Section 781(d)(2)(B), the area served by the AHEC would be in need of psychiatrists. There is, however, no comparable mechanism for the training of medical specialists other than those enumerated in Section 781(d)(2)(C) to "assist in the planning and development of training programs to meet the needs" which could be determined in Section 781(d)(2)(B).

Therefore, in order to provide the flexibility for an AHEC to address particular and specific health manpower training needs envisioned by Section 781(d)(2)(B), we recommend that such Section 781(d)(2)(B) be amended by inserting: "and, in accordance with such assessment, provide for or conduct a medical residency training program in which no fewer than six individuals are enrolled in first-year positions in such program" after "needs".

With regard to Section 794C relating to preventive or community medicine residencies, the APA believes that further emphasis needs to be placed on preventive aspects of mental illness and that the incorporation of psychiatric aspects of prevention is an integral part of any such residency program.

In order to ensure that prevention of mental illness is considered (a key need identified by the President's Commission on Mental Health), we recommend that parenthetical references to psychiatry be included in Section 794C as follows: (1) on page 39 at line 21, insert "(including psychiatry)" after "other clinical specialties;" (2) on page 40 at line 17, insert "(including course content in psychiatry)" after "preventive or community medicine;" and (3) on page 41 at line 21, insert "(including psychiatry)" after "other relevant specialties."

In addition, we endorse amendments which would support approved residency training programs that prepare residents for teaching medical students and other hospital staff in techniques of teaching, supervision, consultation, career development, and evaluation methods suited to the clinical setting. Further, the APA would encourage the inclusion of "biopsychosocial aspects of patient care" in medical school teaching programs because of the frequently inextricable nature of physical and mental illness.

Studies have demonstrated that the quality of medical student teaching is one of the factors related to the percentage of students entering psychiatry, and that higher quality programs have a sufficient well-rounded faculty, varied teaching methods, and a high degree of commitment to students. It follows that to recruit more potential psychiatrists we must conduct good teaching at medical schools, with a high degree of commitment on the part of the faculty. Teaching at the residency level must also involve both instruction in administration and exposure to exciting administrative experiences, teaching in "how to teach," and learning how to work with primary care physicians.

The programs proposed for physician residents to be exposed to the social and behavioral sciences should include a requirement, however, that physician residents (particularly those in primary care) receive training in the biopsychosocial aspects of direct patient care in inpatient and outpatient health care settings.

Our concern and comment is founded on the need for physicians to be able to diagnose, treat where appropriate, and refer when indicated, patients with mental disorders which may present themselves or be perceived as having a

physical etiology. By not specifically understanding and recognizing the varied aspects of mental dysfunction, and the psychological and somatic interrelationships in physical symptomatology, the physician resident may not gain the total knowledge needed to assist patients who come to a general physician for treatment. This is particularly true for primary care physicians, who, according to a 1976 study, treated 43.6% of mental disorders presented to all physicians.

The APA supports the proposal to amend Section 212(j)(1)(D) of the Immigration and Nationality Act which would allow FMGs who have passed the Visa Qualifying Exam (VQE) to come to this country and remain for the period of time required to establish eligibility to take specialty examinations. Current law, which allows FMGs who have passed the VQE to come to the U.S. for two years to pursue medical education and to remain for an additional year if the visitor's home government approves, does not provide such FMG resident physicians adequate time to meet eligibility requirements of most medical specialty certifying boards, requirements which may be assumed to reflect the necessary period of training for a designated specialty. We believe that the proposal in H.R. 6802 to amend Section 212(j)(1)(D) is a reasonable approach which would allow an alien physician to complete residency training. An alien graduate medical education student currently is required to meet the VQE and language requirements, thus assuring his or her competence.

The APA shares the concern that by extending the "substantial disruption waiver" provision, institutions will not be encouraged or forced to address what is predominantly an educational quality issue. We do not wish to discount the service needs of populations served by residency programs which have become dependent on FMGs. Considerable thought should be given to alternative approaches which would improve these programs so that they would be attractive to U.S. medical graduates and so the populations served can receive quality medical care from U.S. medical school graduates or qualified foreign medical graduates.

The APA supports the statutory designation of hospitals with more than 25% FMG residents as health manpower shortage areas as defined in Section 332 of the PHS Act. While most beneficial to psychiatric training, we oppose the proposal allowing for the creditability of service obligation for the period

of graduate medical education received at hospitals with a significant dependence on FMGs. The NHSC program's intent has always been to provide fully qualified physicians to deliver medical care to underserved areas and populations. In fact, the Corps continues to emphasize the placement of physicians who are board-eligible or board-certified. By adopting this creditability provision, while self-serving for psychiatry as a medical specialty, we are concerned that the purpose of the Corps would be compromised and the medical needs of the patients in the service areas would be "short-changed."

The APA has continued to support the activities of the Graduate Medical Education National Advisory Committee (GMENAC) since it was established administratively by the Secretary of HEW. We believe that data and analyses must be assimilated and critiqued by a body such as GMENAC in order to assure that geographic and specialty maldistribution issues are dealt with consistently and in an unbiased manner.

We are gratified with the accomplishments of GMENAC to date and believe its continued existence is essential. We therefore support Title IV of H.R. 6802 which would establish GMENAC statutorily, with defined functions.

We appreciate the opportunity of submitting this statement for your consideration and welcome the opportunity of working with the Committee to ensure that Federal health manpower legislation responds to our citizens who are in need of treatment for mental illness.

HEALTH PROFESSIONS EDUCATION and
CLINICAL MANPOWER TRAINING FACT SHEET

AMERICAN PSYCHIATRIC ASSOCIATION

The FY 82 Reagan budget request refocuses the allocation of Federal funds to "target resources on meeting national priority training needs...". In addition, the HHS background material states that the "principal reason for decreasing aid (via the FY 81 rescission request) is to remove incentives for expanding the supply of health professionals, especially in those fields where the national supply is adequate or anticipated to be in surplus within the near future..." The principal Federal mechanism which has been used to support the psychiatric training programs has been Section 303 of the Public Health Service Act, administered by the Psychiatry Education Branch, of the National Institute on Mental Health, ADAMHA. The HHS budget justification for ADAMHA states that "clinical training is proposed for elimination because Federal subsidies for such training are no longer essential." However, the health professions section of the same HHS budget justification endorses the targeting of health professions training resources on meeting national priority training needs. The final report of the Graduate Medical Education National Advisory Committee (GMENAC) projected a shortage of almost 13,000 psychiatrist (an approximate 30% shortfall) by 1990. Other medical fields for which there are budget requests for continued or new funding are either projected to be in balance or in surplus in 1990. Similar shortage conclusions are documented by the Rand Corporation, the Heritage Foundation, the President's Commission on Mental Health (PCMH), and the FY 1980 Report to the Senate Appropriation Committee. We believe that either categorical authority of funding preference be given to training in shortage specialties and/or disciplines in relation to the severity of documented shortage and service need. This recommendation is both consistent with the overall HHS health professions training rationale and the well established shortage of psychiatrists. Such recommendation is not existent in either the ADAMHA or Health Resources Administration budget justifications relating to Federal support for training assistance, and urge that such change be made.

We are gratified that the Mental Health Systems Act (P.L. 96-398) acknowledges the severe shortage of psychiatrists, endorsing the conclusions of the PCMH and other entities, which recommended increased support of psychiatric residencies. The proposed phase-out of the NIMH clinical manpower training program contradicts the noted credible sources of documentation of a severe shortage of psychiatrists to meet the treatment needs of the 10-15% of the American population with significant mental illness disorders.

Coupled with the need for training funds for psychiatry training programs are changes in reimbursement mechanisms (e.g. Medicare, Medicaid) so that time-based specialties, such as psychiatry, are not penalized at the expense of procedure- and technology-based specialties which are largely inpatient-oriented, the service components of which underwrite a large proportion of the

costs of related residency programs.

In addition, targeted incentives in student loans or service-related scholarships tied either to preference for individuals interested in entering shortage specialties or tax incentives, such as an interest differential, should be seriously examined.

The APA continues to be concerned with the entry and residency training of foreign medical graduates. We believe that H.R. 2056 is a reasonable approach to weaning the U.S. from an unreasonable and unfair (in the "brain drain" context) dependence on foreign trained physicians. The only section which causes us some concern is the extension of the "substantial disruption" waiver provision until December 31, 1981, without requiring any increased obligation for an expedited independence of foreign trained physicians.

FY 82 APPROPRIATIONS FACT SHEET

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

THE AMERICAN PSYCHIATRIC ASSOCIATION

The APA has three major concerns with the FY'82 ADAMHA budget:

1. Research resource allocations for ADAMHA (mental health, alcohol and drug abuse research) are not only insufficient but also inequitable when contrasted to funding for NIH's research activities;
2. The phase out of NIMH clinical manpower training support will exacerbate documented shortages of psychiatrists; and
3. The inclusion of the Mental Health Systems Act (MHSA) in a health services block grant to the states will cause inappropriate institutionalization and the mentally ill will be swept up in the criminal justice system, all cost ineffective.

MENTAL HEALTH RESEARCH

The \$3.521 billion NIH research budget suffered a 3.5% cut in the FY 81 Reagan budget revision. The NIMH comparable research component (extramural and intramural research and research training) was cut 9.1% in the same FY 81 Reagan budget revision. Thus, in order for there to be equity with the NIH rescission, \$9.635 million of the \$15.6 million recommended for rescission needs to be restored for NIMH research, so that it will total \$165.635 million.

For FY 82, NIH research is slated for a 6.6% increase for total \$3.762 billion. NIMH research activities, however, are only recommended to receive a 0.2% increase and total \$176.567 million. Thus, there needs to be an increase of \$10.9 million over the FY 81 recommended rescission level in order to have equity with NIH research levels in the FY 82 budget.

The research activities of NIH and NIMH are complementary and the grant review mechanism permits only highly qualified awards to be made.

CLINICAL MANPOWER

The FY'82 Reagan budget justification for NIMH clinical manpower training support states: "Clinical training is proposed for elimination because Federal subsidies for such training are no longer essential." This is in direct contradiction to the realities of what historic Federal support has accomplished and for which it was designed. For example, as cited recently by the Heritage Foundation, the FY 1970 appropriation for NIMH clinical manpower was, in constant dollar terms, 62% more than the FY 80 funding level. In programmatic terms, there has been a five fold decrease in support of psychiatry training programs during the past decade, and the number of American medical graduates (AMGs) entering psychiatry residencies dropped from 12% to 3.2%. Such a decline was directly related to the significant decline in Federal support. In 1980, about 550 AMGs entered psychiatric residencies. If even 10% had continued to enter these programs (which would have required increased appropriations), the severe shortage currently being experienced by psychiatry would now be much less. Instead, the shortage will be exacerbated with the proposed elimination of clinical manpower training support.

In order to arrest the further decline in AMGs choosing psychiatry and begin to train the number of psychiatrists needed to treat 20-30 million Americans documented as in need of treatment for mental illness, the rescission request for NIMH clinical training in FY 81 (\$4,938,000) should be disapproved. Likewise, the \$8,552,000 reduction requested in the FY 82 revised budget request should be disregarded. The FY 81 continuing resolution of \$23.1 million should be the absolute minimum level for FY'82.

Integral to the rationale for continuing and enhancing Federal aid for psychiatric clinical manpower training programs is the reality that the reimbursement system rewards technology and procedure oriented specialties and, therefore, penalizes time-based specialties, such as psychiatry. One of the reasons the technology and procedure-based specialties have not suffered and have not required Federal or other outside support is due to their largely inpatient-orientation. Such service components underwrite the costs of related residency training programs. These mechanisms and models have the effect of penalizing psychiatry which even has shifted training and treatment largely to ambulatory outpatient settings based on new treatment modalities, recommendations of the President's Commission on Mental Health, Congressional initiatives and third party payment changes. Psychiatry is now suffering because of the success of initiatives such as deinstitutionalization and its responsiveness to other national shifts in health care policy and patient needs.

MHSA/BLOCK GRANT

It is well established that when essential community support mechanisms necessary and appropriate for the care of the mentally ill, as contemplated by the Mental Health Systems Act (MHSA) are not available, resources for these extremely vulnerable populations -- a truism if the MHSA is turned into a health services block grant -- individual states, with few, if any, exceptions, will have no alternative but to turn to more costly and inappropriate institutionalization. Indeed, it is further well documented that without such community support, the mentally ill will be tragically swept up into the most inappropriate and most costly criminal justice system.

COST EFFECTIVENESS OF MENTAL HEALTH CARE

Summaries of Studies

A.	IMPACT OF MENTAL HEALTH TREATMENT	
1.	West German Study (Duehrssen)-----	1
2.	Kaiser-Permanente Study (Follette and Cummings)-----	2
3.	HIP Study (Fink <u>et al.</u>)-----	4
4.	GHA Study (Goldberg <u>et al.</u>)-----	7
5.	Kaiser of Oregon Study (Uris)-----	9
6.	Puget Sound Study (Kogan <u>et al.</u>)-----	11
7.	Blue Cross of Western Pa. Study (Jameson <u>et al.</u>)-----	13
8.	HIP Medicaid Study (Fink and Goldensohn)-----	16
9.	Mexican-American Study (McHugh <u>et al.</u>)-----	18
10.	Four Settings Study (Regier <u>et al.</u>)-----	20
11.	GHA Study (Patterson and Bise)-----	23
12.	Studies Currently Underway	
a.	GHA Study (Goldberg)-----	26
b.	Kaiser-Permanente Study (Follette and Cummings)-----	26
c.	Kaiser of Oakland Study (Harrington)-----	26

1. West Germany Study: Annemarie Duehrssen, "Catamnestic Results on 1,004 Patients After Analytic Psychotherapy," translated by Stephen Sharfstein from article in *Zachr Psycho-som, Med VIII, 2/62, Verlag Fuer Medizinische Psychologie (Goettingen)*.
 - a. Aim of Study: To determine both the change in utilization of all hospital care subsequent to the completion of analytic psychotherapy or psychoanalysis and the success of that treatment in terms of symptoms, employability and self evaluation.
 - b. Setting: The outpatient clinic at Berlin's General Health Insurance Office. The provision of hospital care before or after psychotherapy was organizationally unrelated to the outpatient clinic.
 - c. Benefit: Up to 200 hours of psychotherapy was provided through their national health insurance.
 - d. Study Population: Follow-up medical histories were attempted on 1,004 adults who had completed an average of 100 hours of psychotherapy at the clinic 5 years earlier. Of the 890 who were reachable by mail, 845 were evaluated (647 through doctors' examinations, 104 through letters or questionnaires and 94 through social worker evaluations). These patients came largely from the employed population and their dependents. None were people who lived off their own wealth. The study population appeared to be chronic sufferers in that only 20% described their symptoms as being of a duration shorter than 2 years. Forty-nine percent of the study population were between 25 and 35 years of age, and only 5% were over 50. Thirteen percent had ended their treatment prematurely, and 12% continued their treatment privately after their benefit had been exhausted.
 - e. Types of Therapists: Not mentioned.
 - f. Time Span: Five years following completion of treatment for the study group and an unspecified amount of time prior to treatment for a small number of such patients.
 - g. Comparison Group: None. However, the average hospital days per year for all insured individuals was 2.5 days.
 - h. Findings: The average number of all hospital days per year for the study population before psychotherapy was thought to be about 5.3 days. For the 5 years subsequent to treatment, the average for this group was 0.8 days. The study concluded that such a large improvement would not likely have occurred in the absence of treatment since the symptoms were largely chronic. Furthermore, staff visits were made to a number of those who had been placed on a waiting list and never received treatment at the clinic. There was no spontaneous improvement for these patients. Eighty-one percent of the study population felt that they had been significantly helped by treatment.

2. Kaiser-Permanente Study: William Follette and Nicholas A. Cummings, "Psychiatric Services and Medical Utilization in a Prepaid Health Plan Setting," Medical Care (1-2/67), pp. 25-35.
 - a. Aim of Study: To determine whether the provision of psychiatric services in an HMO is associated with a reduction in the number of medical care visits, outpatient laboratory and x-ray procedures, and days of hospitalization.
 - b. Setting: Kaiser Northern California Health Plan—a prepaid, group practice health care plan with all covered services generally provided within the plan.
 - c. Benefit: Psychiatry was generally not covered on a prepaid basis, but psychiatric services were available to many plan subscribers at a reduced rate.
 - d. Study Population: One hundred and fifty-two adult patients, representing every fifth psychiatric patient whose initial interview occurred during 1960. Fifty-three percent received only the initial interview, 27% received "brief therapy" consisting of two to eight sessions (mean of 6.2), and 20% were engaged in "long-term therapy" comprising more than eight sessions (mean of 33.9). The overall composition of the health plan subscribers was diverse and included most socio-economic groups. Sixty-three percent of the sample were blue collar workers or their dependents, and 52% were women. Ages ranged from 24 to 62 with a mean of 38.
 - e. Types of Therapists: Psychiatrists, clinical psychologists, psychiatric social workers, resident psychiatrists and psychology interns. All were full-time.
 - f. Time Span: One year before the initial interview (base year) and five years after (1959-1964).
 - g. Comparison Group: Each experimental patient was matched with a control patient according to age, sex, socio-economic status, 1959 medical utilization, continuous Health Plan membership for at least 1959 through 1962, and criteria of psychological distress. Psychological distress was determined by the presence of several of 38 weighted types of entries into the medical records during 1959. The comparison group, however, did not receive psychiatric care.
 - h. Findings: The results of the study are summarized in Table A-1.

Table A-1. Impact of Psychotherapy on Mean Medical Care Utilization, One Year Before Psychotherapy (Base Year) Compared to Fifth Year After

Item to Compare	1 S*	Study Group		Aver.	Comp. Group
		2-8 S	9+ S		
Non-psy. Outpat.:					
Base Yr. Visits	11.4	19.0	11.6	13.5	11.4
5th Yr. Visits	4.4	5.7	5.7	5.1	12.9
Signif. of Change	.01	.01	.05	.01	NS
% Change	-61%	-70%	-51%	-62%	+13%
All Outpat. Visits					
% Change	-61%	-67%	-7%	-54%	+13%
All Hosp. Days					
Base Yr.	1.46	1.61	4.94	2.21	2.13
5th Yr.	.63	.85	.68	.71	2.01
Signif. of Change	-	-	-	.05	NS
% Change	-57%	-47%	-86%	-68%	-6%

*S= session(s) of psychotherapy.

Source: derived from Follert and Cummings (1-2/67), tables 3, 4, 6, and 7.

For all three experimental groups, utilization of non-psychiatric medical services dropped significantly. Outpatient utilization declined each year for five years. Inpatient hospital utilization fell for each of the first two years and then began to level off. Medical care utilization by the comparison group, however, underwent no statistically significant changes.

3. HIP Study: Raymond Fink et al., "Psychiatric Treatment and Patterns of Medical Care," unpublished report to NDMH (7/69), pp. 33-51.
 - a. Aim of Study: to use small samples in an exploratory search for the possible impact of psychiatric treatment on the use of outpatient medical services, specifically family doctor, specialist, and laboratory and x-ray services. This was chapter IV of a larger study focusing on referral, utilization of psychiatric services, and mental health staffing patterns.
 - b. Setting: Health Insurance Plan (HIP) of Greater New York--a comprehensive, prepaid group practice program.
 - c. Benefit: Prior to 1965, only a consultative or diagnostic visit with the plan's psychiatrist was covered. During 1965, the benefit was expanded to include subsequent treatment visits.
 - d. Study Population: The 1965-66 Psychiatric Consultation sample was comprised of 112 patients, aged 15 and older, who were seen in psychiatric consultation between October 15, 1965 and May 31, 1966, 73% of whom received at least one treatment visit at the Mental Health Service. Of this sample, 71% were female and 52% were 40 years of age or older.
 - e. Types of Therapists: Not specified in Chapter IV of the study.
 - f. Time Span: One year before study entry date and two years after that date for each patient. The study entry date for those in the 1963 and 1965 Consultation samples was the date they first received psychiatric consultation. For the 1965 Psychiatric Diagnosis and Comparison samples, the 3-year time span began on the date they were seen by their family physicians.
 - g. Comparison Groups: Three other groups were used in the study:
 - (1) 1965 Psychiatric Diagnosis Sample: One hundred and six patients who were reported by their family physicians as having an emotional problem at a time when psychiatric treatment still was not available. Seventy percent were women and 75% were 40 years of age or older. This age factor is significantly different at the .05 level from the study population.
 - (2) 1965 Comparison Sample: One hundred and sixteen patients for whom their family physicians reported no emotional problem for the study period. Fifty-five percent were female and 74% were 40 years of age or older. Both of these factors are significantly different at the .05 level from the age and sex of the study population.
 - (3) 1963 Psychiatric Consultation Sample: Ninety-seven patients who received a diagnostic psychiatric visit only, generally on referral from their family physicians. Fifty-nine percent were women and fifty-five percent were 40 or older.

- h. Findings: Table A-2 contrasts the study population ('65-66 Psychiatric Consultation Group) with each of the three comparison groups with regard to the utilization of each type of service in the year before study entry date (1B) and with regard to the change in utilization for each of the two years after study entry (1A and 2A) when compared with the year before entry:

Table A-2. Impact of Psychotherapy on Outpatient Medical Care Utilization, One Year Before Psychotherapy or Study Entry Date Compared to First and Second Years After

Item to Compare	'65-66 Psych. Consult. Group	'65 Psych. Diag. Group	'65 Comp. Group	'63 Psych. Consult. Group
Family Doctor Visits				
1B*	3.94	3.27	3.34	2.86
1A-1B*	-.24	+.30	+.88	-.84
2A-1B*	-.27	+.19	+.38	-.14
Specialist Visits				
1B	2.67	2.17	1.97	2.39
1A-1B	-.05	+.39	-.28	+.36
2A-1B	-.24	+.08	-.22	-.19
All Physician Visits				
1B	6.61	5.44	5.32	5.25
1A-1B	-.29	+.68	+.59	-.48
2A-1B	-.51	+.28	+.15	-.33
Lab and X-ray Visits				
1B	3.92	3.80	2.53	3.01
1A-1B	-.65	-.20	+.59	-.19
2A-1B	-.57	-.96	-.08	+.03

*Code: 1B= average number of medical visits during the year before either psychotherapy or study entry date.

1A-1B= average change in the number of medical visits made during the first year after study entry date when compared with 1B.

2A-1B= average change in the number of medical visits made during the second year after study entry date when compared with 1B.

Sources: derived from Fink et al. (7/69), Tables IV-2 and IV-3.

When the study population is contrasted with each of the three comparison groups for each of the two years after the study entry dates, there are six comparisons for changes in utilization of each of three types of services: family doctor, specialist, and x-ray and laboratory. In ten of the twelve comparisons for family doctor and specialist services, there is a relatively greater utilization decline for the 1965-66 consultation sample (the study group). This was found to be

statistically significant. However, when these services are aggregated into just six comparisons of total physician services, the study group still shows a greater relative decrease in utilization but not at a statistically significant level. The study group also showed a similar statistically insignificant relative decrease in x-ray and laboratory utilization. The utilization by the study group of all physician services was 8% lower in the third year of the study than in the first year. The study group's utilization of lab and x-ray services declined 15% over the same period. When the portions of each group under 40 years of age are compared, then the study group's relatively greater declines in utilization of lab and x-ray services and in total physician services were statistically significant. However, when the family doctor and specialist services were considered separately, the statistical significance was lost. Finally, when the groups were divided according to sex, no statistically significant comparisons resulted.

4. GHA Study: Irving Goldberg, Goldie Krantz and Ben Locke, "Effect of a Short-Term Outpatient Psychiatric Therapy Benefit on the Utilization of Medical Services in a Prepaid Group Practice Medical Program," Medical Care (9-10/70), pp. 419-28.

- a. Aim of Study: to study the impact of short-term outpatient psychiatric therapy on utilization of non-psychiatric physician services and of laboratory and x-ray services.
- b. Setting: Group Health Association (GHA) of Washington, D.C.--a comprehensive, prepaid group practice program.
- c. Benefit: By January of 1965, 84% of the GHA membership were covered by the GHA mental health benefit. This benefit consisted of up to \$15 for each of 10 outpatient therapy sessions in a membership year. A member was eligible only when he or she suffered from acute mental illness or emotional disorders subject to substantial improvement through short-term outpatient therapy. Eligibility for referral under the benefit was determined by a screening psychiatrist.
- d. Study Population: Two hundred and fifty-six patients who:

- (1) were seen by the screening psychiatrist between November 1, 1964 and October 31, 1965 (the first full year in which the new psychiatric benefit was operative),

- (2) were referred for treatment under the new benefit,

- (3) were GHA members for the full period of the study.

Only 44% of those seen by the screening psychiatrist were found eligible for referral under the benefit. Seventy-seven percent of the study group were Federal employees or their dependents, 83% were Caucasian, 61% were female, and 89% were between the ages of 15 and 64.

- e. Types of Therapists: Psychiatrists and other mental health discipline.
- f. Time Span: The year immediately preceding referral by the screening psychiatrist compared against the year beginning three months after the referral.
- g. Comparison Group: None, but it is possible to compare the study group's per capita utilization with that of the entire plan.
- h. Findings: Table A-3 illustrates psychotherapy's apparent impact on per capita utilization of physician and lab and x-ray visits of the study group compared to the utilization of such services by the GHA general membership.

Table A-3. Impact of Psychotherapy on Mean Outpatient Medical Care Utilization, Year Before Referral Compared to Year After

	<u>Doctor Visits</u>			<u>Lab and X-Ray Visits</u>		
	Year Before	Year After	% Change	Year Before	Year After	% Change
Total Study Group (N=256)	4.94	3.42	-31%	3.11	2.18	-30%
Screening Only (N=70)	-	-	-39%	-	-	-23%
1-9 Therapy Visits (N=75)	-	-	-30%	-	-	-24%
10 or More Visits (N=104)	-	-	-23%	-	-	-35%
Unknown No. of Visits (N=7)	-	-	-50%	-	-	-44%
<hr/>						
GHA General Membership	3.77	3.71	- 2%	5.51*	6.37*	+16%

*These figures appear to relate to lab and x-ray services rather than visits, (with possibility of more than one service per visit)

Source: derived from Goldberg et al. (9-10/70), pp. 423 and 427.

It is interesting that even the subgroup receiving only the psychiatric screening interview had utilization reductions similar to the study group. Apparently, either that session itself was beneficial or many sought psychotherapy elsewhere.

The above reductions in utilization were also consistent across categories of age, race, sex, and psychiatric diagnoses.

5. Kaiser of Oregon Study: Joseph Uris, "Effects of Mental Health Utilization and Diagnosis on General Medical Care Utilization in a Prepaid Clinic Setting," Report by a Western Interstate Commission for Higher Education (WICHE) Intern (Boulder, Colorado, 1974).
 - a. Aim of Study: to determine whether care received in the mental health clinic of a prepaid group practice will lead to fewer general physician office visits.
 - b. Setting: Oregon Region of the Kaiser Foundation Health Plan—a comprehensive, prepaid group practice plan in the Portland/Vancouver area.
 - c. Benefit: not mentioned.
 - d. Study Population: 45 persons who:
 - (1) were diagnosed as having a mental illness during a process of household interviews of 4,000 members selected randomly,
 - (2) utilized the mental health clinic of the Plan during 1970,
 - (3) were full-time members from 1969 to 1972.

Twenty were male and 25 were female.
 - e. Types of Therapists: not specified.
 - f. Time Span: 1969 and 1971
 - g. Comparison Groups: Two such groups were established, whose members matched the study population according to 1969 utilization, age and sex. One such group of 45 was drawn from among 618 persons who were given a mental illness diagnosis during the household interviews but who did not make any visits to the mental health clinic. The other group of 45 was drawn from among those found to neither have a mental illness diagnosis nor to have visited the mental health clinic.
 - h. Findings. All groups experienced a decline from their relatively high levels of non-psychiatric physician office visits in 1969. The declines are presented for each of the groups in Table A-4.

Table A-4. Impact of Psychotherapy on Outpatient Medical Care Utilization, Year Before Year of Psychotherapy or Study Entry Date Compared to Year After

Group	Male (N=20)	Female (N=25)	Total Group (N=45)
Mental Clinic Users			
Aver. 1969 visits	2.55	5.48	4.18
Aver. 1971 visits	1.95	5.12	3.71
% Change	-24%	-7%	-11%
Mental Illness Diag.			
Aver. 1969 visits	2.45	5.52	4.15
Aver. 1971 visits	2.30	4.44	3.48
% Change	-6%	-20%	-16%
No Mental Illness Diag.			
Aver. 1969 visits	2.25	5.40	4.00
Aver. 1971 visits	1.10	4.28	2.86
% Change	-51%	-21%	-28%

Source: derived from Uris (1974), p. 7.

While many of the changes in utilization were large, none was found to be significant at the .05 level. Thus, Uris concluded that no significant change in outpatient health care utilization occurred as a result of either an outpatient mental health intervention or a mental illness diagnosis.

6. Puget Sound Study: William S. Kogan et al., "Impact of Integration of Mental Health Service and Comprehensive Medical Care," Medical Care (11/75), pp. 934-942.

a. Aim of Study:

(1) to explore the impact on general outpatient medical care utilization resulting from an outpatient mental health intervention by using a control group not comprised solely of high utilizers (as the study claims was done by Follette and Cummings);

(2) to discover whether such an impact might be different for high, low and medium utilizers or for prepaid and fee-for-service members.

- b. Setting: Group Health Cooperative of Puget Sound (Seattle)—a comprehensive group practice plan with both prepaid and fee-for-service members.

- c. Benefit: not mentioned.

- d. Study Populations: One study group consisted of 148 prepaid Plan members who were seen in the mental health service during 1967. The other study group was comprised of 171 fee-for-service members who also were treated in the mental health service during 1967. Both study groups were subdivided into high (14 or more medical visits per year), medium (4-13 visits), and low (0-3 visits) utilizers for 1966, the baseline year.

- e. Types of Therapists: not mentioned.

- f. Time Span: 20 quarter years before the first visit to the mental health service and 9 quarters afterwards (5 years before and 2½ years after). Anywhere from 30 to 50% of the members of the various groups did not belong to the Plan for the full 20 previous quarters, and data on about 75% did not extend for the full 9 subsequent quarters (because data collection stopped at the end of the second quarter of 1969).

- g. Comparison Groups: All the members of the prepaid study group were matched with individuals not seen in the mental health service during 1967. Matched variables were age, sex, length of Plan membership, position in family, and size of family. Care was taken to avoid appreciable differences between groups as to demographic variables (race, education, occupational level, marital status, religion and residential stability). The comparison groups were also split into high, medium and low utilizers according to the same numerical criteria by which the study groups were split up. However, since the mean utilization rate in 1966 for the comparison groups was 50 to 60% lower than for the study groups, the comparison groups ended up with a greater portion of their members classified as low utilizers than did the study groups. Also, it was not stated whether the matching as to age, sex, and other variables held up within the various subgroups.

- h. Findings: Two comparisons were made, and the results were presented on line graphs showing patterns for mean number of visits for each quarter before and after being seen in the mental health service. Actual means for any particular quarter were not given and thus have to be interpolated from the graphs.

The first comparison was between each study group and its comparison group as to all health care visits, including mental health. Both comparison groups began with utilization rates of about one visit per quarter. These rates remained relatively stable over the entire time span of the study. Both study groups began with utilization rates only slightly higher than their comparison groups. However, about two years prior to being seen in the mental health service, the utilization rate of each study group began to rise until it peaked at the time of the intervention at about three times the rate for its comparison group. This pattern then reversed itself over the next two years as the utilization rates of the study groups returned to their previous levels. The authors suggested that this return might just as easily have occurred without a mental health intervention.

They attempted to substantiate this contention through the second comparison, which looked solely at medical care utilization. Here they graphed the mean number of visits for each of the high, medium and low utilizer subgroups within the four groups. The low utilizers in each study group had histories of low mean utilization similar to their comparison groups. The low utilizers in each of the study groups experienced a sharp peak in utilization at the time of their psychotherapy and then dropped back gradually to their previous level of utilization after a couple years. However, this return was not quite as clear-cut for the low utilizers in the prepaid study group. The moderate utilizers in each study group had roughly the same consistent mean utilization patterns as their comparison groups except for the sharp peak that occurred at the time of their mental health intervention. Finally the high utilizers in both the study and the comparison groups clearly exhibited the phenomenon of regression to the mean. All of these high utilizers had had a utilization rate of about 2 visits per quarter year during the several years preceding the mental health intervention for the study groups. Then, in the year before that intervention, the rate climbed to about six visits per quarter for the high utilizers in both the study and comparison groups. Finally, in the couple years after the intervention, the utilization rate for all these groups fell back to or below where it had previously been. This return was initially somewhat slower for the high utilizers in the study groups.

7. Blue Cross of Western Pennsylvania Study: John Jameson et al., "The Effects of Outpatient Psychiatric Utilization on the Cost of Providing Third Party Coverage," Blue Cross of Western Pennsylvania, Research Series 18 (12/76).

a. Aim of Study:

- (1) to discern the impact of a CMHC psychiatric intervention which was at least partly outpatient on the utilization and cost of the inpatient and outpatient medical care services covered by Blue Cross.
- (2) to determine the extent to which prior level of medical care utilization affects the findings.

b. Setting: A Blue Cross subscriber group in Southwestern Pennsylvania comprised of 1,500 employees and families of a heavy industry plant.

c. Benefit: Beginning in 1968, outpatient services in a local CMHC were covered, including the following for any 12 month period: up to 50 group therapy sessions, up to 50 individual therapy sessions, collateral visits with family members, and psychoactive drugs. The benefit covered the full cost of the first 15 visits and two-thirds of the cost thereafter. Certification of continuing need had to be renewed monthly. The employees' major medical plan did cover psychiatric services from private practitioners after a \$100 deductible and up to \$20 per visit thereafter. The report did not specify what the inpatient psychiatric benefit was.

d. Study Group: 136 individuals who had at least one psychotherapy visit between September, 1970 and August, 1974. The average number of such visits for the group was 6.1 with 32% having only one visit, 37% with 2 to 8 visits, 14% with 9 to 15 visits, and 17% with 16 to 49 visits. In addition, 27 underwent psychiatric hospitalizations, all but 4 of which occurred within a month of their outpatient treatments. The average age of the employees was over 40, and 43% had had no high school education. 57% of the study group were adult, and 57% were female. Of the adults, 65% were female; whereas only 37% of the dependents were female. Between the beginning of the study and their first psychotherapy visit, 34% of the study group had incurred no Blue Cross-reimbursable medical-surgical charges, 45% had incurred charges of less than \$20 per month, and 21% had incurred charges of more than \$20 per month.

e. Types of Therapists: not specified.

f. Time Span: September, 1970 through August, 1974.

g. Comparison Groups:

- (1) All those in the subscriber group who had no outpatient psychotherapy contact during the above time span;

(2) The 421 persons in the subscriber group who were high utilizers for the first 24 months of the study. "High" was defined as average medical-surgical costs of over \$20 per month.

- h. Findings: Each member of the study group had up to 48 exposure months depending on how long he had belonged to the subscriber group. These exposure months were identified as pre or post-psychiatric contact. Pre and post-contact health care utilization rates were determined by dividing the total number of services before and after psychiatric contact by the total number of exposure months before and after. However, since the subscriber group as a whole had experienced both a drop in inpatient admissions per 1,000 members and an upward trend in outpatient visits during the 4-year period, adjustments were made to wash out the impact of these exogenous trends. Only Blue Cross data were used since data were not available for services covered by Blue Shield or major medical insurance or paid for by the subscriber. The resultant findings are summarized below:

Table A-5. Impact of Psychiatric Treatment in a CMHC on Blue-Cross Medical and Psychiatric Care Reimbursements over Four Years

<u>Item to Compare</u>	<u>All Subscribers</u>	<u>Study Group (N = 136)</u>		<u>% Change</u>
		<u>Pre-Contact</u>	<u>Post-Contact</u>	
Aver. Exposure Months	-	21.3	26.7	-
Medical-Surgical				
Inpat. Days/Mo.	.084	.192	.087	-55%
Outpat. Days/Mo.	.040	.074	.030	-59%
Cost/Patient/Mo.	\$8.02	\$16.47	\$7.06	-57%
Psychiatric				
Inpat. Days/Mo.	.003	.100	.055	-45%
Outpat. Days/Mo.	0	0	.662	-
Cost/Patient/Mo.	\$.17	\$ 3.93	\$7.08	+80%
Total				
Cost/Patient/Mo.	\$8.19	\$20.40	\$14.14	-31%

Source: derived from Jameson et al. (12/76), p.22.

All three of the declines in medical-surgical utilization and costs were statistically significant at the .05 level. These costs declined to a level below that of the average for the entire subscriber group. Furthermore, additional analysis of the data indicated that this phenomenon of reduced medical-surgical utilization following outpatient psychotherapy was independent of age, sex or employment level (salaried versus hourly).

However, these reductions were found to be very strongly related to the level of prior utilization. The following table splits the study group according to utilization levels mentioned above and includes a comparison group of those who were high utilizers during the first 24 months:

Table A-6. Impact of Psychiatric Treatment in a CMHC on Blue-Cross Medical and Psychiatric Care Reimbursements Over Four Years According to Prior Level of Medical Care Utilization

Pre-Contact Utilization Subgroup	Aver. Exposure Months	Med.-Surg. Per Capita Cost/Mo.	Psychiatric Per Capita Cost/Mo.	Total Per Capita Cost/Mo.
<u>None</u>				
Pre-Contact (N=41)	14.8	\$ 0.00	\$ 0.00	\$ 0.00
Post-Contact (N=56)	33.0	8.53	6.70	15.23
% Change	-	-	-	-
<u>Low</u>				
Pre-Contact (N=54)	25.2	4.40	2.35	6.75
Post-Contact (N=54)	23.7	4.13	7.36	11.49
% Change	-	-6%	+213%	+70%
<u>High</u>				
Pre-Contact (N=26)	20.6	67.54	12.94	80.48
Post-Contact (N=26)	22.0	8.82	7.30	16.12
% Change	-	-87%	-44%	-80%
<u>Comp. High</u>				
1st 24 Mos. (N=521)	21.0	51.35	0.00	51.35
2nd 24 Mos. (N=521)	21.0	19.82	0.00	19.82
% Change	-	-61%	-	-61%

Source: derived from Jameson et al. (12/76), p. 32.

As can be observed above, practically all of the reduction in utilization by the study group came from the one-fifth of the group who had previously been high utilizers. The drop in utilization by the comparison group was also very large but not quite as dramatic as that of the study group high utilizers. However, the difference between the utilization declines by each of these two groups may not be statistically significant because of the small number of study group high utilizers.

8. HIP Medicaid Study: Raymond Fink and Sidney Goldensohn, "Use of Mental Health Services by Medicaid Enrollees in a Prepaid Group Practice," NIMH contract HSM-42-71-70 (2/77).
- a. Aim of Study: To study the impact of psychiatric treatment of Medicaid enrollees on their utilization of outpatient medical services, specifically family physician visits, specialist visits, and x-ray and laboratory services.
 - b. Setting: Health Insurance Plan (HIP) Queens-Nassau Mental Health Services and the six medical groups affiliated with HIP in the Borough of Queens. HIP is a comprehensive, prepaid group practice program.
 - c. Benefit: Unlimited outpatient mental health treatment.
 - d. Study Group: 169 Medicaid enrollees who received psychiatric treatment at the mental health unit during 1969 or 1970 and for whom medical care utilization data was available for the full year before and after that treatment. 40% were male. 52% were under 25 years of age, 30% were 25 to 44 years old, and 18% were 45 or older.
 - e. Types of Therapists: not specified.
 - f. Time Span: One year before psychiatric treatment and one year after.
 - g. Comparison Group: 141 Medicaid enrollees randomly selected from among those for whom their physician listed a condition that could be diagnosed as mental, emotional or psychological. Data was also available on these persons for the full year before and after this psychiatric diagnosis. A household survey later showed that 62% of these persons had not had any discussion with an HIP family doctor about family emotional problems. Also, the age and sex characteristics of this group were extremely different than those of the study group. Only 19% were male. Also, 19% were under 25 years of age, 25% were 25 to 44 years old, and 56% were 45 or older.
 - h. Findings: The changes in outpatient medical care utilization by the study (treatment) and comparison (diagnosis only) groups in the year after treatment or diagnosis is indicated in Table A-7.

Table A-7. Impact of Psychotherapy on Mean Outpatient Medical Care Utilization, Year Before Psychotherapy or Diagnosis Compared to Year After

<u>Item to Compare</u>	<u>Treatment Group</u>			<u>Diagnosis Only Group</u>		
	<u>Total</u>	<u>Male</u>	<u>Under 25</u>	<u>Total</u>	<u>Male</u>	<u>Under 25</u>
Composition of Group						
Number (N)	169	68	88	141	27	27
Male	40%	100%	-	19%	100%	-
Under Age 25	52%	-	100%	19%	-	100%
Family Doctor Visits						
Year Before	3.8	1.9	2.2	4.7	3.9	2.5
Year After	3.4	2.3	2.2	4.8	3.6	3.2
Net Change	-.4	+.5	+.1	+.2	-.3	+.8
% Change	-11%	+26%	+5%	+4%	-8%	+32%
Specialist Visits						
Year Before	2.0	1.1	.9	1.3	1.0	1.3
Year After	1.7	1.1	.9	1.6	1.2	.8
Net Change	-.3	0	0	+.3	+.2	-.4
% Change	-15%	0%	0%	+23%	+20%	-31%
Lab & X-ray Services						
Year Before	10.3	4.5	4.6	8.9	7.1	6.1
Year After	7.7	4.8	3.8	11.4	9.4	7.0
Net Change	-2.6	+.3	-.8	+2.4	+2.3	+1.0
% Change	-25%	+7%	-17%	+27%	+32%	+16%

Source: derived from Fink and Goldensohn (2/77), Tables 2A-5B.

When the total groups are compared, the treatment group appears to have experienced a substantial drop in utilization of all three types of services whereas the diagnosis-only group increased its utilization in each case. However, when the two characteristics on which the two groups were severely mismatched (age and sex) are singled out and compared, the differences in utilization pattern between these sub-groups become much less consistent.

9. Mexican-American Study: James P. McHugh et al., "Relationships between Mental Health Treatment and Medical Utilization among Low-Income Mexican American Patients: Some Preliminary Findings," Medical Care (5/77), pp. 439-44.
- a. Aim of Study:
 - (1) to explore whether mental health treatment at a neighborhood health center leads to a reduced number of medical visits;
 - (2) to study whether the prior level of medical care utilization affects the findings.
 - b. Setting: A relatively new neighborhood health center in a low-income, Mexican-American section of a southwestern city.
 - c. Benefit: not specified.
 - d. Study Group: 119 patients who were referred to the clinic's mental health service and who completed their treatment during the period of the study. 75% were women (compared with 55% of general patients); 42% had less than a 9th grade education; 14% were on welfare; 34% were unemployed; 76% were Mexican-American. 40% had only one psychiatric visit, 42% had two to four visits, and 17% had five or more visits.
 - e. Types of Therapists: a psychiatrist, a clinical psychology graduate student, a social worker and three bachelor-level social work associates. Therapy consisted mainly of brief supportive treatment, crisis intervention and sometimes practical intervention.
 - f. Time Span: February 1, 1971 through February 28, 1972 (13 months).
 - g. Comparison Group: none
 - h. Findings: Table A-8 illustrates the changes in outpatient medical care utilization according to the amount of psychotherapy received.

Table A-8. Changes in Outpatient Medical Care Utilization Before, During, and After Psychotherapy

Number of Psychotherapy Sessions	Medical Encounters/Month			% Change
	Before	During	After	
1	.535	1.813	.887	+ 66%
2	.546	2.133	1.056	+ 93%
3	.458	1.350	.478	+ 4%
4	.409	1.786	1.064	+160%
5	.830	2.248	1.207	+ 45%
Total Group (N=119)	.561	1,900	.967	+ 72%

Source: derived from McHugh et al. (5/77), p. 441.

All of the above differences were found significant at the .05 level. Here the net result of a psychotherapy intervention was an increased rather than decreased level of general medical care utilization. No significant interaction was discovered between the number of therapy sessions received and the pattern of medical care utilization before, during and after those therapy sessions.

The study data were also analyzed as to the possibility of different findings depending upon whether patients had previously been high (1.0 more visits per month), moderate (.5 to 1.0 visits per month), or low (fewer than .5 visits per month) utilizers of general medical care at the neighborhood health center. The mean utilization for low utilizers rose by .565 visits per month from the period before to the period after psychotherapy. The mean utilization rate for the moderate group rose by .333 visits per month and for the high utilizers by .057 visits per month. The apparent trend for low utilizers to experience greater increases in medical care utilization than the high utilizers was found to be significant only at the .10 level.

10. Four Settings Study. Darrel A. Regier et al., "Epidemiological and Health Services Research Findings in Four Organized Health/Mental Health Service Settings," paper presented at the ADAMHA Health Maintenance Organization Conference (11/30/77).
 - a. Aim of Study: to explore the possible effect of referral to mental health services upon the utilization of general medical services.
This was a small part of a larger report on various research findings.
 - b. Settings:
 - (1) Columbia Medical Plan (CMP), a prepaid group practice serving a mostly upper middle-class, suburban population in Columbia, Maryland;
 - (2) Marshfield Clinic (MC), a comprehensive health care group providing care on both a prepaid (HMO) and a fee-for-service (FFS) basis in rural Marshfield, Wisconsin;
 - (3) Bunker Hill Health Center (BHHC), a subsidized, fee-for-service, comprehensive neighborhood health center which is affiliated with Massachusetts General Hospital and which serves a predominantly working class and indigent urban population in the Charlestown section of Boston.
 - c. Benefit:
 - (1) CMP - \$10 copayment and no limit on number of mental health visits;
 - (2) MC/HMO - maximum of 15 mental health visits/person/year with an additional 15 visits after a three-month treatment hiatus;
 - (3) MC/FFS - limited only by the availability of third party insurance payments, out-of-pocket monies, and various subsidies;
 - (4) BHHC - same as MC/FFS.
 - d. Study Group: Those patients in each setting who both had a diagnosis of mental disorder and made at least one subsequent visit to the mental health department of their plan by the end of 1975. Although the number of patients meeting both of these criteria was not specified in the article, that number was supplied by one of the authors:
 - (1) CMP - 987
 - (2) MC/HMO - 541
 - (3) MC/FFS - 258
 - (4) BHHC - 957
 - e. Types of Therapists: not specified.

f. Time Span: one year (1975).

g. Comparison Group: Those patients in each setting who had a diagnosis of mental disorder but who did not make a subsequent visit to the mental health department of their plan by the end of 1975.

(1) CMP - 172

(2) MC/HMO - 379

(3) MC/FFS - 555

(4) BHHC - 491

h. Findings: Table A-9 summarizes the basic findings.

Table A-9. Average Number of Visits to Medical Departments by Study and Comparison Groups in Four Settings, 1975

<u>Setting</u>	<u>Comparison Group</u>	<u>Study Group</u>	<u>% Fewer Medical Visits By Study Group</u>
Columbia Medical Plan	7.1	6.7	6%
Marshfield Clinic			
prepaid	8.7	6.1	30%
fee-for-service	6.7	4.8	28%
Bunker Hill Health Center	6.2	4.9	21%

Source: derived from Regier et al. (11/77), figure 4.

The authors note that shared responsibility by both health and mental health departments for patients with mental disorders is associated with fewer medical services for those patients. Presumably, this is due to the provision of more appropriate care. However, the authors caution that these data must be interpreted with care since the study and comparison groups most likely have major differences in diagnostic as well as other characteristics.

By combining the above data with cost and utilization data, the authors were able to compute the net cost of providing mental health services per patient treated.

Table A-10. Average Net Costs Per Patient in Mental Health Services for Four Study Groups, 1975

<u>Setting</u>	<u>Gross Mental Health Cost</u>	<u>Savings in Other Depts.</u> ¹	<u>Savings as % of Gross</u>	<u>Net Mental Health Cost</u>
Columbia Medical Plan	\$330	\$14	4%	316
Marshfield Clinic				
prepaid	120	80	67%	40
fee-for-service	99	60	61%	39
Bunker Hill Health Center	407	26	6%	381

¹ Cost savings per patient are based upon reduced utilization of outpatient general medical services by study group members as compared to utilization of such services by comparison group members. Source: derived from Regier *et al.* (11/77), table 11.

11. GHA Study. Daniel Patterson and Bernard Bise, "Report Pursuant to NIMH Contract Number 282-77-0219-MS," January, 1978.

- a. Aim of Study: "to develop a valid statistical methodology to determine if psychiatric intervention will reduce the utilization of other medical care services."
- b. Setting: Group Health Association (GHA) of Washington, D.C.—a comprehensive, prepaid group practice program.
- c. Benefit: a psychiatric evaluation upon referral by a GHA physician and a maximum of 16 outpatient visits.
- d. Study Population: 952 patients and their families out of 1274 who were the subjects of "new evaluations" by the GHA Department of Psychiatry during 1976. The remaining patients were eliminated from the study because of inaccurate or incomplete data. Also, most of the analyses were done on simply the 426 patients who had had a psychiatric intervention during the first six months of 1976. In comparison to the total GHA membership, this smaller group of 426 patients had the following proportional differences: 9% more females, 48% fewer children under 20 years of age, 13% fewer young adults (20 to 29 years old), 89% more middle-age adults (30 to 44 years old), and 59% more elderly (65 years and older). Diagnostic impressions for this group were as follows: transient situational disorder (33%), psychoneurosis (18%), personality disorder (6%), psychosis (1%), psycho-physio disorder (1%), other (30%), unknown (11%).
- e. Types of Therapists: Psychiatrists and other mental health disciplines.
- f. Time Span: Three months before the month in which psychiatric intervention occurred and three months after for the full group of 952 patients and twelve months before and after for the subgroup of 426 patients.
- g. Comparison Group: None, but some comparisons can be made between the study group and the entire plan membership.
- h. Findings: Tables A-11 and A-12 illustrate the basic findings.

Table A-11. Impact of Psychiatric Intervention on Utilization of Outpatient Medical Care and Ancillary Services for 952 Patients (3 Months After vs. 3 Months Before)

<u>Type of Service</u>	<u>Mean No. of Services Per Patient</u>		
	<u>3 Mos. Before</u>	<u>3 Mos. After</u>	<u>% Change</u>
Medical	1.99	1.62	-19%
Laboratory	1.68	1.44	-14%
X-ray	.30	.21	-30%

Source: derived from Patterson and Bise (1/78), Exhibits VI and VIII.

Table A-12. Impact of Psychiatric Intervention on Utilization of Outpatient Medical Care and Ancillary Services for 426 Patients (One Year After vs. One Year Before)

<u>Type of Service</u>	<u>Mean No. of Services Per Patient</u>			<u>Aver. for All GHA</u>
	<u>1 Year Before</u>	<u>1 Year After</u>	<u>% Change</u>	
Medical	6.0	5.7	- 5%	3.9
Laboratory	7.6	6.4	-16%	3.5
X-ray	1.2	0.8	-33%	0.6

Source: derived from Patterson and Bise (1/78), Exhibit XIII.

A month-by-month breakdown of the smaller group's pattern of medical care utilization is also presented in the form of a graph, highlights of which are presented in Table A-13.

Table A-13. Medical Care Utilization Pattern for One Year Before and One Year After the Month of Psychiatric Intervention for 426 Patients

<u>Item to Compare</u>	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>
	<u>12th Through 9th Mo. Before</u>	<u>Month of Intervention</u>	<u>1 Month After</u>	<u>9th Through 12th Mo. After</u>
Med. Care Visits/Mo.	170	370	257	145
% Change from A	-	+118%	-	-15%
% Change from B	-	-	-31%	-61%

Source: derived from Patterson and Bise (1/78), Exhibit V and from personal communication with Bise (2/28/78).

From the graph that Patterson and Bise constructed, it appears that the number of medical care visits was relatively stable from the twelfth through the ninth months before psychiatric intervention and then began climbing erratically over the next eight months

until a peak was reached during the month of the intervention. Then there was a sharp drop in utilization during the first month after the intervention, followed first by a leveling off and later by another sharp drop and a leveling off again during the ninth through the twelfth months. The utilization in this last four-month period was about 15% lower than the utilization in the first four-month period.

Patterson and Bise concluded that "The study demonstrated no significant reduction in medical utilization when selected patients served as their own controls." (p. 3). This conclusion was based on the probable insignificance of a one-year reduction in utilization of only 5%. Also, while the 19% utilization reduction from the three month period before intervention to the three month period after intervention appears significant, Patterson and Bise cautioned that an upward distortion exists in the period before intervention because most patients have just had a medical visit out of which came their psychiatric referral. They also cautioned that the laboratory and x-ray reductions are even more suspect because most physicians tend to order more lab tests and x-rays at the beginning of their assessment of a patient's complaints than they would later on.

Another conclusion was that psychiatric patients appear to be high utilizers of medical services. This was based upon the comparison of the study group with the total GHA membership as shown in Table A-12.

Finally, Patterson, Patterson and Bise identify as their most noteworthy finding the reduction in medical visits by the families of psychiatric patients. They found that, in the three months after a family member had received psychiatric help, the family of the patient averaged 12% fewer medical visits than they had made in the three month period before intervention.

12. Studies Currently Underway.

- a. GRA Study: Mr. Goldberg is currently working with utilization data on a later study group. This second study has a number of contextual differences from the first one, including the presence of an on-going psychiatric program instead of a new one, a benefit which has been increased from 10 to 16 visits, and a total absence from the study group of people who had had a psychiatric referral during the preceding year. Family members, however, could have had such a referral. The new study is again for a two year period but with a four month interval instead of a 3 month one. This study goes beyond the old one by examining the medical utilization of the families of referred patients, by including hospital utilization, and by using one comparison group of matched cases but with no psychiatric referral and another comparison group consisting of those referred for psychiatric evaluation but found ineligible for the psychiatric benefit.
- b. Kaiser-Permanente Study: Drs. Follette and Cummings are currently engaged in a new study hoping to replicate the results of the previous one but with a prospective experimental design that should prove responsive to criticisms of that earlier study.
- c. Kaiser of Oakland Study: In an NIMH-funded research project entitled, "Systems Approach to Mental Health Care in an HMO Model," Robert Harrington is testing several hypotheses, including:
 - (1) that an integrated system of mental health services increases medical care effectiveness and reduces unnecessary medical and surgical utilization;
 - (2) that early appraisal of psychosocial determinants of a person's health and illness reduces both unnecessary hospitalization and the frequency of chronic conditions.

DEPARTMENT OF HEALTH SERVICES

714/744 P. STREET
SACRAMENTO, CA 95814
(916) 445-1248



March 16, 1981

Honorable Henry Waxman, Chairman
Subcommittee on Health
2415 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Waxman:

The State of California is committed to the development of health promotion activities as a means of reducing health care costs, improving health status, and raising the productivity of our population. The recently established Governor's Council on Wellness and Physical Fitness is a demonstration of Governor Brown's commitment to shifting the focus of our health system toward health and well-being rather than illness. The Department of Health Services has a variety of health promotion programs, including the Health Education/Risk Reduction Program that is aiming at local efforts to promote a higher level of health among the people of California.

The training of health professionals is an essential ingredient of a strategy to develop health promotion activities. Through modifications of existing federal policies, and through the creation of new policy directions, an opportunity now exists to redirect the allocation of health resources into the more cost-effective areas of health promotion and primary care. I urge your Committee to incorporate a strong new policy direction into any health professions legislation this year to begin the process of turning our health care system around.

The enclosed testimony on health professions legislation is designed to help you in that process. Thank you for the opportunity to share our views.

Sincerely,

A handwritten signature in cursive script that reads 'Beverlee A. Myers'.

Beverlee A. Myers
Director

Enclosure

CALIFORNIA DEPARTMENT OF HEALTH SERVICES:
TESTIMONY ON HEALTH PROFESSIONS LEGISLATION

The California Department of Health Services wishes to submit the following testimony on health professions bills to be considered by the United States Congress:

It is the policy of the California Department of Health Services to shift the allocation of health care resources toward the positive promotion of health rather than the treatment of late-stage disease processes. The cost-effectiveness of disease prevention is believed to exceed that of curative treatment of disease. It is further believed that the productivity and quality of human life can be enhanced through health promotion activities such as physical fitness, stress management, nutritional awareness, environmental sensitivity, and increased self-responsibility.

To the extent that health promotion activities require the direction by trained health professionals, the implementation of the state policy is constrained by the availability of such professionals. The Federal Government has a variety of programs affecting the mix of skills obtained by health professionals throughout the educational system. The State of California urges the Congress to direct more of our nation's health training resources toward the development of preventive health and health promotion skills.

The persons receiving training in preventive health (including environmental and occupational health) and health promotion should not be limited to physicians. Emerging mid-level health practitioners provide a means of expanding services in a more cost-effective manner than can be achieved through a reliance on physicians alone. An increased number of mid-level practitioners have the potential to improve the availability of primary care services in a less costly fashion. The use of mid-level practitioners can also facilitate a shift from an illness-oriented health system to a system oriented toward health and well-being.

The following points relate to specific issues of manpower legislation:

1. General Duties of the Secretary of Health and Human Services:

The Secretary should be required to support activities designed to empower individuals to maintain and improve personal health status through accessibility to nutrition information, physical fitness resources, stress management techniques, and other health promotion resources.

2. Capitation:

Capitation grants should be weighted toward those health professionals that provide primary care, preventive health services, and health promotion services.

3. Incentive grants:

Incentive grants should be designed to increase the numbers of primary care providers as a percentage of the total number of health professionals; incentives for the education of physician extenders (physician

assistants, nurse practitioners, nurse midwives) should be created.

4. Start-up grants:

Grants for the initiation of programs to train non-physician primary care providers such as physician assistants, nurse practitioners, and nurse midwives; apprenticeship programs and on-the-job training for nurses should be supported; programs at nursery schools that train non-physician primary care providers should be supported.

5. HEAL Loans and Health Professions Student Loans:

Student loans should be weighted toward those programs that train primary care providers and health promotion specialists. Loans should be extended to programs training chiropractors and other alternative health providers deemed capable of improving primary health care services.

6. Loan repayment:

The Secretary should be authorized to repay student loans for health professionals providing primary care to underserved areas.

7. NHSC Scholarships:

The NHSC scholarships should be expanded to include the training of non-physician primary care providers including physicians assistants, nurse practitioners, nurse midwives, and nutrition counselors.

8. Family Medicine Departments:

Grants to medical and osteopathy schools to train family medicine practitioners should be required to train non-physician providers and to train physicians to practice family medicine in cooperation with the non-physician providers in a primary care team approach.

9. Public Health and Health Administration:

Special emphasis should be given to the development and expansion of programs in disease prevention and health promotion; including women's health, geriatrics, environmental health, occupational health, and nutrition.

To the extent that funds are limited, public health programs should train non-physician personnel that will increase the availability of preventive health and health prevention activities at a lower cost per individual practitioner.

10. Allied Health Professions:

Funds should be allocated to the training of more mid-level health practitioners capable of providing preventive health and health promotion services at a lower cost than physicians.

11. Special Projects:

Section 788(d) of PHS Act should require the Secretary to continue the availability of the 5th Pathway Program to United States citizens participating in the Becas Para Azatlan Program sponsored by the Mexican Government. Under the Becas Para Azatlan Program, Chicano students from the United States are provided scholarships to attend undergraduate and graduate school in Mexico. Upon graduation from medical school in Mexico, the students require additional training in the U.S. before becoming fully qualified to practice medicine. At present, the 5th Pathway Program is available for that purpose, but it may not continue to be available due to the increased supply of physicians graduating from United States' medical schools. While discontinuation of the 5th Pathway Program may (or may not) be appropriate, a specialized version of the program should be continued to meet the needs of Chicano students participating in the Becas Para Azatlan Program. Those students agree to serve Chicano areas in the United States as a condition of their receiving scholarships from the Mexican Government. Since the Chicano communities are generally medically underserved, the Becas Para Azatlan Program represents a means of raising the health status of Chicano populations in the United States.

GEORGETOWN UNIVERSITY
WASHINGTON, D.C. 20057

OFFICE OF THE PRESIDENT
SPECIAL ASSISTANT FOR
FEDERAL RELATIONS

March 17, 1981

200-1,25-4411

The Honorable Henry A. Waxman
United States House of Representatives
1721 Longworth House Office Building
Washington, D.C. 20515

Dear Congressman Waxman:

As you consider HR 2004 and the authorization of new health manpower legislation, we would like to bring to your attention some provisions of critical concern to health professions schools in general, and Georgetown University Medical Center in particular.

HEAL Program

As you know, the Health Educations Assistance Loan (HEAL) program was part of the Health Professions Education Assistance Act which expired September 30, 1980. To assure that banks would continue to participate in the program, it was necessary to amend (in PL 96-359) the interest provisions of the act by removing the 12% interest cap, and calculating the interest at the 91 day Treasury bill rate plus 3.5%. At the same time, the Act was changed to permit HEAL borrowers to borrow from other Federally guaranteed loan programs at the same time.

It is critically important that additional modifications be made in the HEAL program in any new authorizing legislation (many of these provisions are included in HR 2004):

- Providing for authorization of the program for several years. (We concur in the HR 2004 provision for four years, to allow for stability in the program.)
- Raising the lending limits for students in Medicine, Osteopathy and Dentistry to \$20,000 with cumulative limits of \$80,000. We prefer that the limits be specifically raised to \$20,000 (with cumulative limits of \$80,000) without the qualifying statement now in HR 2004 that "the Secretary may increase the total of such loans..."
- Permitting accrual of interest during deferral periods.
- Establishing a longer deferral (four years) for residency, National Health Service Corps service, etc.
- Deleting the present limit of the loan to 50% of the class at each institution. (This is essential if the loan program is to be administered in an equitable fashion.)
- Permitting graduated repayment schedule.
- Raising the forgiveness-for-service provision in section 735 so the amount of forgiveness any year would be any year's loan up to \$10,000 and accrued interest on that loan.

As other sources of financial aid are drying up for our health professions students, the HEAL program, which was formerly regarded as a "last-resort loan" is rapidly becoming a major financial aid instrument. Since the HEAL program pays its own way, it is essential to remove restrictive language which hinders the availability of the loan to health professions students.

Other Student Assistance

As we represented to your committee in the past Congress, we urge the adoption of a student assistance program in which some of our health professions students would be eligible for loans with less-than-market interest. While we have welcomed the Health Professions Student Loan of sec.739 ff. in prior years, we urge adoption of a loan program based on long-term Secretary of Treasury obligations with the students paying full interest, which would provide more loan capital than the HPSL program, at little direct cost to the Federal Government.

Nursing Programs

We urge continuation of Title VIII of the Public Health Service Act on Nurse Training. At Georgetown, we have particular need for continued authorization of Advanced nurse training programs (sec.821); traineeships for advanced training (sec.830) and student loans (secs.836 and 837), as presently in HR 2004. Support of nursing education is most important to help meet the critical national nursing shortage today. Graduate training programs and traineeships are particularly important to develop the nursing leadership cadres which must meet the challenges of the professions which have resulted in the present nationwide shortage of nurses.

Construction Grants and Loans

We urge the adoption of sec.726, amended to include grants and loans for construction of new projects for teaching and research facilities when essential for accreditation of an eligible institution.

We would appreciate this letter being included in the record of your hearings on HR 2004 and we would be delighted to discuss these matters further with you and your staff.

On behalf of our President (Timothy S. Healy, S.J.) and Chancellor (Matthew F. McNulty, Jr., Sc.D.), we thank you.

Sincerely,

Mary S. Albert

MARY S. ALBERT
Coordinator of Intergovernmental
Relations, Georgetown University
Medical Center

T. Byron Collins

T. BYRON COLLINS, S.J.
Special Assistant to the President for
Federal Relations

cc: James Scheuer Anthony Moffett
Thomas Luken Richard Shelby
Doug Walgren Phil Gramm
Barbara Mikulski Mickey Leland
Ron Wyden John Dingell
James Florio

SUGGESTED LANGUAGE FOR CONSTRUCTION LOANS, Section 203, HR 2004

This language would permit construction grants and loans to be made to eligible institutions for research and teaching institutions necessary for accreditation.

Section 203 (a) Section 726(a) is amended by (1) striking out "construction projects" in the first sentence and inserting in lieu thereof "projects for the construction, remodeling, renovation or alteration of teaching or research facilities" and by changing "1980" to "1984."

(b) Section 726 (b) is amended by (1) inserting "and research" after "teaching;" (2) by inserting "necessary for accreditation of an eligible institution" after "facilities" and (3) by inserting "before October 1, 1984" after "loan has been made" and (4) by striking out "during the period beginning July 1, 1981, and ending with the close of September 30, 1980."


AMERICAN DENTAL ASSOCIATION

WASHINGTON OFFICE • SUITE 1004 / 1101—17TH STREET, N.W. • WASHINGTON, D.C. 20036 • PHONE 202/833-3036

March 18, 1981

The Honorable Henry Waxman
 Chairman, Subcommittee on
 Health and the Environment
 2418 Rayburn House Office Bldg.
 Washington, D.C. 20510

Dear Chairman Waxman:

I am writing to express the views of the American Dental Association on legislation to amend and extend the Health Professions Educational Assistance Act (P.L. 94-484). Last year the Association was afforded the opportunity to testify before the Subcommittee and to submit a detailed record statement on this important issue. Our comments in this letter are intended to emphasize certain aspects of federal health manpower assistance with which the Association has a particular concern. We respectfully request that these recommendations be included within the hearing record.

Institutional Support

Studies conducted by government and private entities over the last several years have shown that the collective capacity of the nation's dental schools is sufficient to meet and exceed the current and projected demand for dental services. The Association is in accord with these findings and therefore reiterates the position taken many times in the past that the government's support of the country's dental schools should not be linked to a formula that has already burdened the system by requiring or encouraging the admission of additional students.

A recognition that we have achieved an adequate supply of health care practitioners does not, however, relieve Congress and the Executive of the obligation to continue supporting the enterprise which they have promoted and encouraged. Continuity and predictability of revenue is as important to the health education system as it is for any large and complex activity. Dental education in particular rests upon an extremely fragile economic base. Between

1970 and 1980 the average annual cost to train a dental student increased by over 120 percent. The current educational costs to a dental school exceeds \$24,000 yearly - a level which is one of the highest among the health profession.

Schools of dentistry are presently receiving over \$12 million in annual capitation grant support. Because of the inability of many schools to generate replacement funds, the American Dental Association urges the Subcommittee to give serious consideration to the establishment of an alternate mechanism for providing institutional assistance. Such a funding authority should not, as stated earlier, be linked to a student enrollment formula. Rather it should be structured to ensure an adequate and stable level of federal support calculated as a percentage of a school's instructional budget or non-federal expenditures. Previous studies by the Institute of Medicine of the National Academy of Sciences include specific recommendations on such an approach.

The Bill, H.R. 2004, before the Subcommittee proposes to phase-out capitation grants over two years. We believe that the existing requirements which dental schools must meet in order to receive this assistance are no longer appropriate and should be repealed for this phase-out period. The provision under Section 771 of the current law regarding student increases for dental schools is clearly not needed at this time and the cost of maintaining an off-site dental training program continues to exceed the sums which schools of dentistry may reasonably expect to obtain through the appropriations process.

Student Assistance

The American Dental Association believes that a comprehensive and financially viable program of health professions student aid should be accorded a top priority in any renewal of the health manpower law. Our position on this issue is prompted by a concern that a prospective withdrawal of federal institutional support will force many dental schools to raise tuition to unacceptably high levels. The consequence of this action is already evident in the precipitous decline in dental school applications which has occurred since 1974. Between the academic years 1973-74 and 1979-80, the average tuition rate at all dental schools increased by 126. During the same period the number of individuals applying to dental schools fell by 26 percent. The most recent data available to the Association indicates that a sizeable majority of the more than 22,000

dental students require financial assistance to complete their education. It is reasonable to assume that the absolute number of students seeking aid, as well as the level of assistance required, will grow in proportion to the additional increases in tuition which can be expected to occur in the next few years.

It is important, we believe, that a student assistance program be responsive to the needs of the participant while in school rather than on a perception of income in later professional life. The ADA endorses an extension of the Health Professions Student Loan Program as proposed in H. R. 2004. Authorization levels for this important authority should, however, be increased by at least 50 percent over those contained in the bill. The Health Education Assistance Loan (HEAL) Program urgently requires an interest subsidy provision if it is to become a meaningful mechanism for student aid. Finally we support a retention of the Exceptional Financial Need Scholarship authority.

Dental General Practice Residence

Section 219 of H. R. 2004 proposes to continue the authority for awarding federal assistance for dental general practice residency training. These programs have been most effective in providing future dental practitioners with the skills and experience necessary for the provision of comprehensive primary dental care. The Association urges the adoption of this provision in the bill.

Preventive Dentistry

Section 794 C would restore a more direct federal role in supporting school based programs of community or preventive dentistry. The ADA has a long-standing record of support for these effective and relevant activities and recommends that the Subcommittee approve this section of H. R. 2004.

National Health Service Corps

Last year the Association expressed a strong concern over the cost, program philosophy and projected size of the National Health Service Corps. Specifically, the Association objected to:

- The number of Corps dental personnel who have been placed in areas of marginal need;
- The shift in emphasis away from solo practice settings to the assignment of Corps dentists to fixed-site health centers and,
- The failure to provide a meaningful role for local dental societies in the designation of shortage areas and the placement of Corps dental personnel.

The Association is encouraged that H. R. 2004 contains proposed amendments which address certain of these concerns. An expanded statutory role for local health professions societies in the shortage area designation process and in the possible placement of Corps personnel to these areas is most welcome. We do not, however, concur in the proposed expansion in funds to be authorized for National Health Service Corps scholarships. It is important to recognize that future requirements for Corps personnel are not a function of the number of designated shortage areas but rather of the existence of a viable sponsor and a site in which those practitioners can effectively serve. Over the next four years more than 700 dental students will graduate with a scholarship obligation to serve in the National Health Service Corps. Sites for 355 Corps dentists currently exist. Assuming for the moment that (1) none of these current Corps dental sites convert to a self-sustaining private practice--and thus continue to be available for future placements, and (2) all of the estimated 150 additional requests for a Corps dentist now pending in the Department are found to be valid, we find that the NHSC will have about 500 assignment opportunities for the 700 plus dental students now in the pipeline. This dilemma is compounded when Corps personnel extend their service beyond the obligation period, as well as by the additional number of "volunteer" Corps dentists who must be placed annually. In the opinion of the American Dental Association, this has led, and will continue to lead, to a situation in which considerable pressure is exerted upon NHSC regional offices to generate applications for Corps dentists. We believe this has produced a situation in which many of the sites that have been identified for placement are located in areas of marginal need. For that reason, we recommend that no funds be authorized for dental NHSC scholarship for fiscal years 1982-1984.

Sincerely,

Wilfred A. Springer

Wilfred A. Springer, D.D.S.
Chairman
Council on Legislation



AMERICAN OSTEOPATHIC
HOSPITAL ASSOCIATION

930 Busse Highway/Park Ridge, Illinois 60068
Telephone 312/692-2351

March 18, 1981

Hon. Henry Waxman, Chairman
Subcommittee on Health & the Environment
House Energy & Commerce Committee
Washington, D.C. 20515

Dear Mr. Chairman:

This correspondence will present the views of the American Osteopathic Hospital Association on your bill, HR 2004, the Health Professions Educational Assistance and Nurse Training Amendments of 1981.

It should be noted at the outset that this Association generally supports the testimony presented by the American Association of Colleges of Osteopathic Medicine.

General Comments

Throughout most of its existence, the osteopathic profession has been committed to primary care and to the correction of both geographic and specialty maldistribution among health care professionals. Nearly 90 percent of the more than 17,000 osteopathic physicians in this country are engaged in primary care; more than a third of these physicians practice in communities having a population of less than 50,000. Approximately half of the nation's more than 200 osteopathic hospitals are located in these same sized communities.

We are especially pleased at the continued support in HR 2004 for the establishment of departments of family medicine in osteopathic colleges; for family medicine, general internal medicine and general pediatrics programs; and for nurse training where the bill encourages an expansion of the existing pool of nursing personnel.

We particularly support the continued funding of clinical training programs in primary care. There are significant expenses incurred by hospitals in conducting such programs. Clinical programs in the specialties are more able to generate sufficient income to defray much of their costs, but primary care is seldom able to do so. If the reimbursement formula is not altered to meet such costs, we believe the continued viability of these programs will be jeopardized. The financial requirements of osteopathic hospitals must be met if they are to continue to be capable of providing primary care clinical instruction to the family/general practitioners of tomorrow.

The AOAHA also supports those programs which assist predoctoral education, faculty development, and remote-site ambulatory care training which are discussed in detail in the testimony of the American Association of Colleges of Osteopathic Medicine.

Specific Comments

We support the funding provided in Section 215 for the establishment of departments of family medicine in osteopathic and medical schools. We are particularly pleased to see the amendment to Section 780(b)(1)(D). The current requirement in Section 780 of PL 94-484 which requires that recipients of Section 780 funds have "control" over family practice residency training programs has created considerable difficulty for osteopathic hospitals due to its inappropriateness to the structure of osteopathic medical education. Unlike allopathic medical schools, the preferred method of operation for osteopathic residency training programs is through formal and informal affiliation agreements between a college and one or more teaching hospitals. This Association, along with the American Osteopathic Association and the American Association of Colleges of Osteopathic Medicine, have jointly concluded that a revision of existing statutory language to reflect the acceptability of an affiliation agreement as an alternative to "control" can best accommodate the unique structure of graduate osteopathic medical education. We applaud the addition of this amendment to Section 780.

We are also pleased to see the addition of hospitals as eligible entities to receive grants under Section 784, General Internal Medicine and General Pediatrics. We believe such an addition will contribute significantly to the training of physicians in these critical areas and will help to eliminate the imbalance between general and specialty physicians.

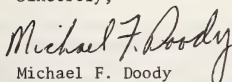
We strongly support the increase in funding for family medicine training programs in Section 219 of HR 2004. In our view, this program has been one of the most successful embodied in PL 94-484 in promoting the increase in the numbers of family/general practitioners in this country. We encourage its continuation and, as mentioned earlier, we support changes in the reimbursement mechanism which will result in adequate recognition of the financial requirements of osteopathic hospitals in the conduct of such programs.

Finally, we are encouraged by the continuation of support for nurse training embodied in Title III, Sections 302, 308 and 309 of HR 2004. As has been noted on numerous occasions, there is a nationwide shortage of approximately 100,000 nurses. We believe this situation is becoming critical in a number of areas, and that the federal government can help to encourage the training of sufficient numbers of nursing personnel to alleviate this problem.

In conclusion, we believe HR 2004 addresses those areas of health professions education most in need of support and will help to correct both the imbalance between the specialties and family/general practice and the geographic maldistribution of physicians in this country. Osteopathic hospitals will continue to take the lead in the production of family physicians as we have for nearly 100 years and we appreciate the recognition of our efforts embodied in HR 2004.

Should you or the Subcommittee on Health and the Environment have any questions regarding our comments, we would be most pleased to respond to them.

Sincerely,

A handwritten signature in dark ink, reading "Michael F. Doody". The signature is written in a cursive style with a large, stylized "M" and "D".

Michael F. Doody
President



American College of Surgeons

FOUNDED BY SURGEONS OF THE UNITED STATES AND CANADA, 1913

55 EAST ERIE STREET CHICAGO, ILLINOIS 60611 AREA CODE 312-664-4050

C. ROLLINS HANLON, M.D., F.A.C.S.
DIRECTOR

March 19, 1981

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health and the Environment
Committee on Energy and Commerce
United States House of Representatives
2415 Rayburn House Office Building
Washington, D.C. 20515

Re: H.R. 2004, Health Professions Educational Assistance
and Nurse Training Amendments

H.R. 2056, Amendment to Immigration and Nationality Act

Dear Mr. Chairman:

The American College of Surgeons wishes to highlight our major concerns and submit supportive material for the record in connection with recent hearings of the Subcommittee on proposed health manpower legislation.

Our main concern with the proposed health professions education legislation is that there be no sudden or drastic changes in federal aid to medical education. While we recognize the need to reduce all federal expenditures, a gradual reduction that will allow schools and students to find alternative financing methods is preferable.

We are opposed to the provision in H.R. 2004 that would give the Graduate Medical Education National Advisory Committee (GMENAC) statutory authority. The monitoring and adjustment of physician education is more appropriately done voluntarily by the private sector.

We support a proposed amendment to the Immigration and Nationality Act in H.R. 2056 that would allow foreign medical graduates to stay in the United States long enough to complete specialty training requiring more than the current two to three year limit.

These points are explained in greater detail in the enclosed documents.

ACS Report on Physician Manpower
ACS Report on GMENAC
ACS Bulletin article on GMENAC
Factsheet and background statement on foreign medical graduate legislation
(prepared for the 96th Congress)

We would be pleased to be of further assistance during your deliberations on this subject.

Sincerely,

C. Rollins Hanlon
C. Rollins Hanlon, MD, FACS

JOHN P. PERRIN, DIRECTOR

Washington Office

499 S. CAPITOL STREET, S.W., SUITE 104
WASHINGTON, D.C. 20003 TELEPHONE 202 554-5245*American Osteopathic Association*

March 31, 1981

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
House Energy and Commerce Committee
2418 Rayburn House Office Building
Washington, D.C. 21515

Dear Mr. Chairman:

The American Osteopathic Association has carefully reviewed the provisions of H.R. 2004, the Health Professions Education Assistance and Nurse Training Amendments of 1981, and wishes to present, for the record, its comments relative to the bill. At the outset, we wish to note our appreciation for your continued sensitivity to the need for adequate and appropriate Federal support for the training of health care professions personnel, generally, and specifically for your awareness of and support for the unique role which osteopathic physicians play in the nation's health manpower pool.

Although osteopathic physicians comprise only about 5% of the total physician population in the United States, they provide health care services to over 10% of the nation's population. More significantly, and, consistent with Congressionally recognized national needs, over 90% of the 18,000 practicing osteopathic physicians provide primary health care services, predominately as general practitioners. Moreover, 50.5% of these physicians provide care in communities of 50,000 or less and 16.9% in communities of 500,000 or more. We believe that the profession's historic distribution pattern which disproportionately serves the nation's largest and smallest communities represents an important contribution toward meeting another national health care goal of providing health care services in medically underserved areas.

The osteopathic profession has experienced rapid growth, during the past decade, in response to the discrete demand for osteopathic health care services and the general demand for more primary care physicians. We believe that continued, carefully planned growth in osteopathic manpower is indicated and, accordingly, offer the following comments with respect to H.R. 2004.

Special Project Grants And Contracts

We strongly support your commitment to continued Federal support for training programs in family medicine, general internal medicine and general pediatrics and for the establishment of Departments of Family Medicine. These projects have helped initiate and sustain high quality postgraduate training programs in osteopathic community teaching hospitals which train the vast majority of osteopathic physicians. Similarly, those programs which support pre-doctoral educational development in the primary care areas such as curriculum development and faculty training complement and reinforce our osteopathic training model, which has contributed to the production of significant numbers of highly capable primary care practitioners.

The financial drain on osteopathic hospitals occasioned by the provision of postgraduate training must be addressed if we are to continue to assure the availability of adequate numbers of postgraduate training positions in primary care clinical instruction.

There are two issues within the special project area which concern us. First, the bill does not appear to continue start-up assistance for schools of osteopathic medicine. While we appreciate the fiscal restraints which dictate reduced levels of funding, two of our osteopathic institutions which have previously received multi-year start-up assistance commitments under the existing law will have their program developments significantly impaired if start-up assistance is preemptorily withdrawn prior to the completion of projects which were predicated on a line of Federal funding. Thus, while new commitments for start-up assistance may not be in order, we believe that it is imperative that pre-existing commitments be honored.

Secondly, we have a concern relative to Section 230 of the bill, which amends Section 794D of the PHS Act. While we heartily applaud the Chairman's interest in promoting enhanced health manpower resources for preventative medicine, as evidenced by inclusion of Section 230, we believe that the selection of residency training programs in preventative medicine as the exclusive vehicle for such enhancement represents a serious mistake, in both philosophical and fiscal terms.

Allopathic medicine has evolved as a constellation of specialties. Its structure has fragmented health care, increased the cost of educating physicians and, because it is acute and disease oriented, actually militates against preventative medicine.

Apparently, allopathic medicine's answer to the now recognized significant omission of preventative medicine in its basic educational experience has been the creation of another new specialty.

By contrast, there are no residency training programs for preventative medicine under the auspices of the AOA, and none are planned. The reason is profoundly important. The central precept of osteopathic medicine, both philosophically and in practice, is the prevention of disease and disfunction. We do not believe that preventative medicine should be relegated to the status of a specialty discipline. The osteopathic educational model integrates preventative medicine into all aspects of predoctoral and postdoctoral training. Osteopathic medical education emphasizes the interrelationship between the neuromusculoskeletal system and all other body systems in maintaining health and preventing and reversing disease and disfunction.

We respectfully invite your attention and support of the osteopathic educational model as the better and less costly approach to the training of preventative medicine personnel.

We realize that our observations and recommendations may not be well received nor positively critiqued by allopathic educators. However, we believe that it is imperative that congressional initiatives in promoting preventative medicine get off in the right direction.

We sincerely hope that you will explore this issue with us more fully, before the legislation leaves the Committee.

Institutional Support

We appreciate the Chairman's sensitivity to the need for continued, albeit reduced institutional support. While such general support has been increasingly perceived as unnecessary, the simple fact is that alternative sources of funding are not readily identifiable. The inescapable consequences of a reduction or elimination of general institutional support will be tuition increases or educational program curtailment, or both.

We believe that there may be other funding mechanisms which could, either partially or entirely, replace general institutional support as it has existed heretofore; and, we are committed to working with the Subcommittee in exploring any workable short or long term alternatives.

Student Assistance

We appreciate your commitment to the maintenance of a variety of student assistance programs. The combination of Federally guaranteed loans, HEAL loans, HPSL loans, and Exceptional Financial Need Scholarships will help insure that students will matriculate, according to their demonstrated ability, rather than their immediate financial status.

The AOA strongly supports two provisions of Section 205 of H.R. 2004. We concur with the commitment to raise the annual Federally Insured Student Loan ceiling and to provide for payback deferral, during periods of residency, internship and externship training and NHSC service.

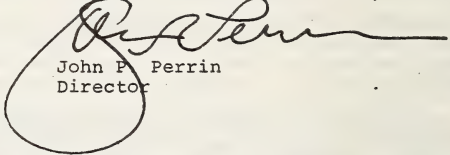
National Health Service Corps

The AOA supports continuation of the NHSC and its scholarship program. These programs have assisted students while helping to insure that medical care will be delivered to medically underserved areas. Osteopathic students have traditionally participated heavily in the NHSC scholarship program and have tended to remain as private practitioners in underserved areas.

In conclusion, we believe that H.R. 2004 represents a balanced and reasonable response to the need for continued support for health manpower, in the context of the existing economic climate.

We look forward to working with you and your staff in the further development of this legislation.

Sincerely,



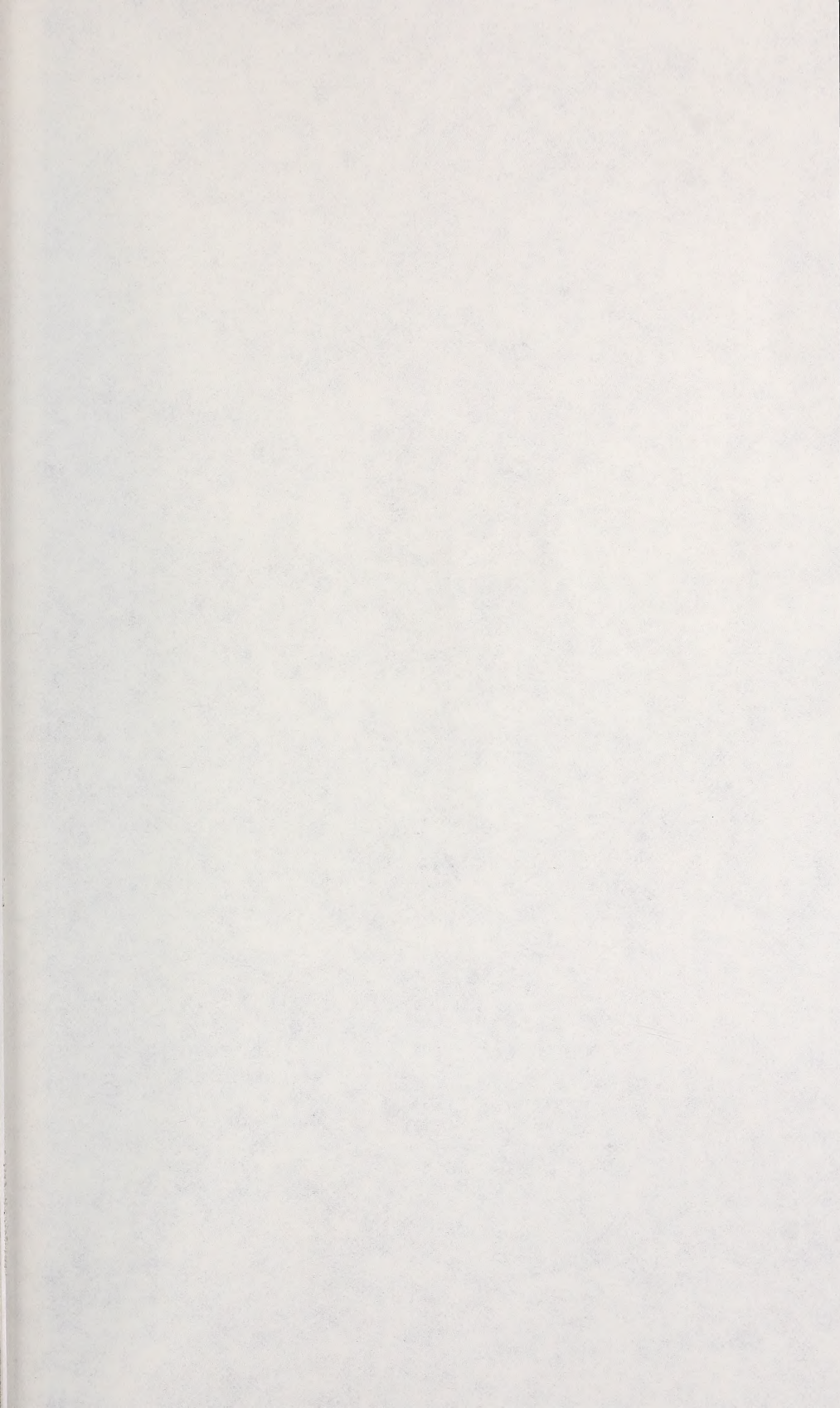
John P. Perrin
Director

JPP/trj

cc: Members, Subcommittee on Health and the Environment

[Whereupon, at 12:20 p.m., the hearing was adjourned.]

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